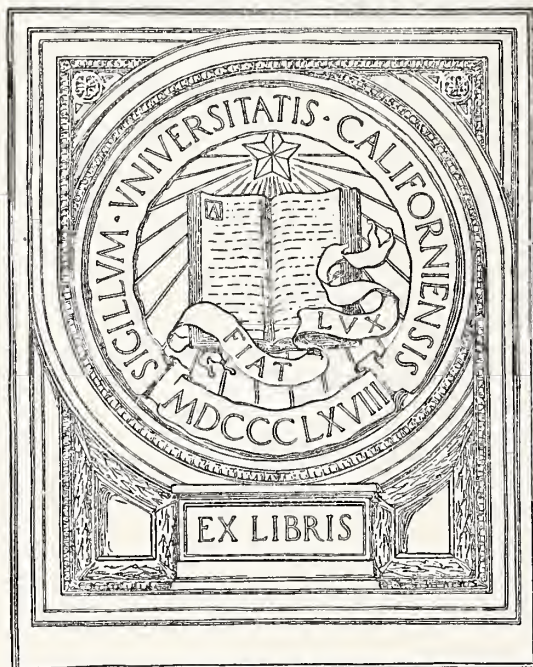






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Vol. XVIII

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No. 1

# Connecticut State Medical Journal

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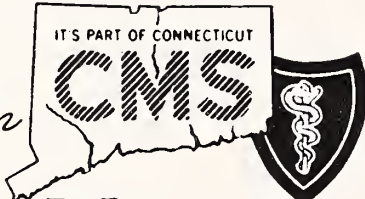


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# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVIII

JANUARY, 1954

No. 1

## SMOKING IN RELATION TO LUNG CANCER A Follow-up Study

E. CUYLER HAMMOND, SC.D., *New York City*

---

The Author. *Director, Statistical Research Section, American Cancer Society; Professor of Biometry, Yale University, Department of Public Health; Director, Graduate Studies, Department of Statistics, Yale University*

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### SUMMARY

The problem of the relationship of lung cancer to smoking is reviewed from an historical standpoint. The three suspicious factors involved are named and what evidence available to establish these factors as causes is furnished.

Two methods of conducting epidemiological studies are pointed out, the historic and the follow-up. The author's program of study by the follow-up method is described in detail. No results as yet can be reported.

EVER since Sir Walter Raleigh had a pail of water poured over his head by someone who thought he was on fire, smoking has been accused of everything imaginable from arson on up. At one time in England it was thought to be such a potent and beneficial drug that it should be used only with a doctor's prescription. Later, moralists preached that it was an instrument of the devil. In more recent times, clinical and laboratory studies have been made to determine the acute effects of smoking, particularly on the circulatory system. The chronic effects of smoking over a period of many years are not so easily determined.

Tobacco smoke contains at least four substances which are highly toxic when administered in large doses, these being carbon monoxide, nicotine, arsenic,<sup>1</sup> and tar. In addition, it has been recently reported that tobacco contains small amounts of radioactive potassium.<sup>2</sup> Whether or not extremely small doses administered over a very long period of time by way of smoking produces serious disorders is another matter. One could theorize that the body builds up an effective immunity or one could equally well argue that the toxic effect is cumulative. Animal experiments may throw some light on the matter, but the only way to determine the facts is to study the long term effects on human beings.

It is of interest to note, that tobacco smoke also contains a substance which may perhaps offer a considerable measure of protection from some of the toxic agents. I refer to the tiny particles of carbon of which smoke is largely composed. Finely divided carbon has the property of absorbing and thereby deactivating a great many chemical substances. Therefore, the available amount of free, active, toxic agents in tobacco smoke may be greatly reduced. If so, it is possible that filters which remove many of the carbon particles from smoke may do more harm than good.

In 1928, Lombard<sup>3</sup> and others in the Massachusetts state health department made an analysis of records collected by the Visiting Nurse Association and found heavy smoking to be more common in the cancer group than in the controls. In their sample, heavy smoking was largely pipe smoking and was particularly more common in those individuals with cancer of the buccal cavity. It should be noted that

at that time cancer of the lung was a relatively rare disease and caused only 2,400 deaths in the United States in 1928.

Several years later, acting on this lead, the Massachusetts state health department obtained information on the use of tobacco among 2,927 male patients over 40 who visited a cancer clinic.<sup>4</sup> They again found a definite association between the use of tobacco and cancer of the buccal cavity, but also found an association between the use of tobacco and the occurrence of cancer of the respiratory tract. This finding did not attract wide interest at the time, probably because of the low incidence of lung cancer.

#### WHITE MALE CANCER DEATH RATES\* BY SITE United States, 1933-1948 SLIDE NO.1

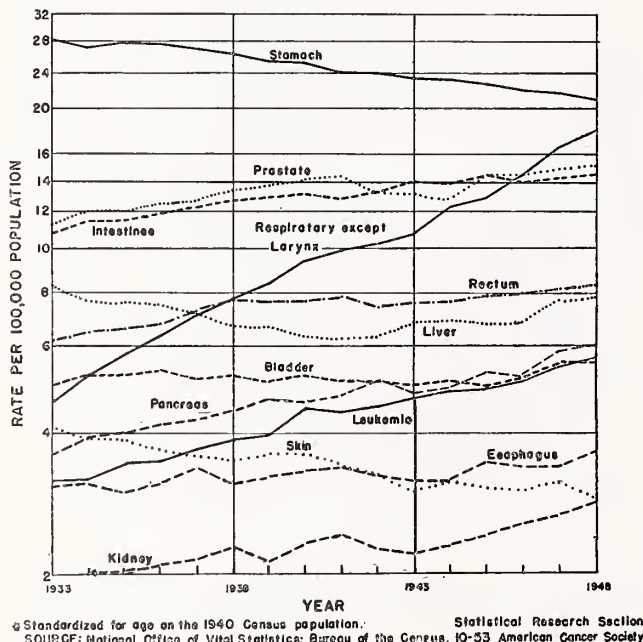


FIGURE 1

Now let us see what has taken place since 1928. As shown in Figure 1, the age standardized death rates for most sites of cancer among males have changed very little over the last several decades. Male death rates have declined somewhat for cancer of the stomach and skin, and have risen somewhat for cancer of the prostate and intestines. However, male death rates from cancer of the respiratory system (except larynx), mainly primary cancer of the lung, have increased dramatically from a standardized rate of 4.6 in 1933 to a standardized rate of 17.8 in 1948. I chose this particular period of years for the illustration because complete figures for the

#### WHITE FEMALE CANCER DEATH RATES\* BY SITE United States, 1933-1948 SLIDE NO.1

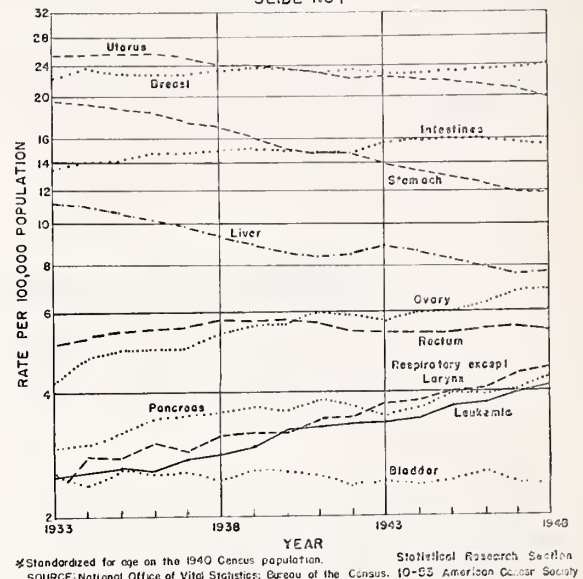


FIGURE 2

United States were first available in 1933 and a change in reporting procedure took place in 1949. However, it is clear that the increase has continued up to the present time. In terms of numbers, approximately 1,500 men in the United States died of lung cancer in 1928 and it is estimated that 17,400 men died of this cause in 1952, almost a twelve fold increase in just 24 years.

An increase in standardized lung cancer death rates also took place in the female population, but the relative change was not as great as among males (see figure 2). It is estimated that about 3,600 women died of lung cancer in the United States in 1952. Thus the total toll from this disease for males and females together stands at about 21,000 deaths per year and is increasing at the rate of about 1,000 more deaths in each succeeding year. Clearly it is a health problem of the first order of magnitude.

Two other statistical facts are of interest in this connection. Bronchogenic cancer is largely a disease of later life, the peak death rate among males occurring in the age group 65-69 and among females in the age group 75-79 (see Figure 3). Why the death rate should decline again in later life is the subject of much debate at the present time. The other fact is that according to official reports, lung cancer death rates are considerably higher in urban areas than in rural areas. It is possible that this is due to difficulties in the reporting system. For example, it may



be that the apparent urban-rural relationship in lung cancer is due merely to the fact that when old people living in the country get sick they have a tendency to move to the home of a married son or daughter in the city and, if they die, their residence is apt to be reported as urban rather than rural. Therefore, we are not sure whether or not this apparent difference in death rates is real.

In searching for an environmental factor which might be responsible for the increase in lung cancer, one might be suspicious of any substance which exhibits all or most of the following characteristics:

LUNG & BRONCHUS CANCER DEATH RATES, BY AGE & SEX  
White Population of the United States, 1933-1936 and 1945-1948

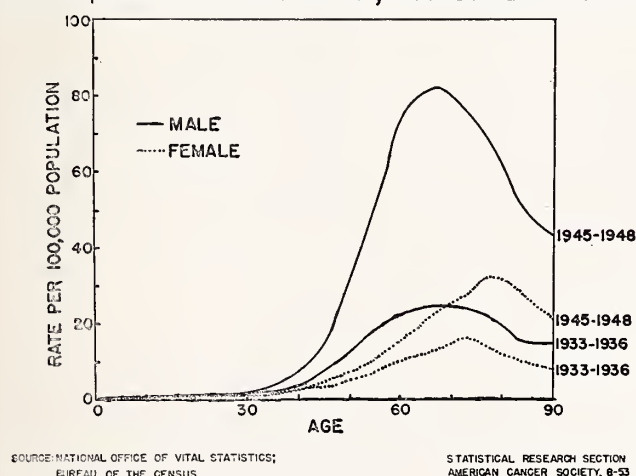


FIGURE 3

(a) something inhaled into the lungs, particularly if it contains chemicals which can produce tumors in experimental animals; (b) something to which a great many people are exposed in all parts of Europe and the United States; (c) something to which people have been increasingly exposed during the last several decades; (d) something to which more men than women are heavily exposed; and (e) something to which city dwellers are more heavily exposed than country dwellers.

On the basis of these considerations alone, the finger of suspicion would seem to point straight to no less than three factors: namely, (1) air pollution from coal and oil furnaces, (2) exhaust fumes from automobiles, and (3) cigarette smoking. No one of these three suspects can be exonerated on the basis of evidence available at present and perhaps all of them are partially guilty. However, I will confine my remarks to the evidence relating to smoking, and more particularly, to cigarette smoking.

The evidence so far collected is of three types: (1) a time trend; (2) laboratory studies on the composition of tobacco smoke and its effect on experimental animals; and (3) statistical studies similar to the original work done by Lombard. The time trend consists of an association between an increase in the sale of cigarettes and the increase in the death rate from lung cancer. The consumption of cigarettes in the United States and most European countries increased abruptly at the time of World War I and has been increasing ever since. However, the habit was at first largely confined to men and it was some years before a large proportion of women took it up. I hardly need tell an audience composed of statisticians that time trend associations are often misleading. Nevertheless, if it is assumed that a time lag of 10 to 20 years exists between exposure to a carcinogenic substance and the development of lung cancer, then the trend in smoking habits could account for both the sex difference and the increase in lung cancer death rates. Of course this is no proof that a cause and effect relationship exists between the two factors.

The laboratory evidence again in itself gives no positive proof that cigarette smoking causes lung cancer, but it is highly suggestive. Very recently<sup>5</sup> laboratory workers have succeeded in producing cancer by applying tar distilled from cigarette smoke to the skin of mice. The first cancer appeared about one year after the first application of cigarette tar and within two years 44 per cent of the animals developed cancer.

After the first report of an association between smoking and human cancer was released by Lombard in 1928, a period of 22 years elapsed before additional evidence of the same sort appeared in the literature except for one paper by Potter and Tully.<sup>4</sup> Then, in 1950, the results of four similar studies were published on the subject.<sup>6,7,8,9</sup> The details varied somewhat, but in each instance the investigators questioned lung cancer patients and a control group of people without lung cancer about their past and present smoking habits. All of these investigators found that a larger percentage of lung cancer patients admitted to a history of smoking, particularly heavy cigarette smoking, than did the control group of people without lung cancer. However, the degree of association found between cigarette smoking and lung cancer differed widely in the several studies. The per cent of smokers in the con-

trol groups was so high that although a statistically significant difference was found between the lung cancer groups and the control groups, the degree of the difference was subject to a very large sampling error.

Although no one of the three types of evidence just described would be sufficient in itself as a basis for positive conclusions, all three taken together certainly build up a strong case for the conclusion that smoking does in fact increase to some degree the probability that an individual will develop lung cancer. However, the most critical evidence comes from the studies on human subjects, so we should consider whether or not it is reliable.

Broadly speaking, there are two major methods by which epidemiological studies can be conducted. These are usually called the "historic method" and the "follow-up method" or, as Professor E. B. Wilson has so aptly phrased it, the "backward method" and the "forward method."

The "backward method" consists of questioning a selected group of patients with a specified disease about things which they have done or things which happened to them in the past. A so-called "control group" is similarly questioned, an attempt being made to select for this group individuals who appear similar to the patients in all respects except that they do not have the disease in question. A comparison is then made between the answers given by the two groups. The one virtue of this method is that under favorable circumstances it can be carried out quickly and at little expense. The disadvantages of the method are manifold, so much so that some statisticians believe that it leads to erroneous conclusions more often than to correct conclusions. Among the more important difficulties are: (a) psychological biases in answering questions dependent upon past experience, present circumstances, and the attitude of the interviewer or the phraseology of the questionnaire; (b) difficulties in selecting truly comparable experimental and control groups for questioning and the likelihood of unavoidable biases in this selection; and (c) a purely statistical fallacy recently discovered by Dr. Joseph Berkson of the Mayo Clinic.<sup>10</sup> Berkson has demonstrated that even if no association exists between two conditions in the general population, an association is very likely to exist in the hospital population even if there are no selective biases of the type usually considered.

The "forward" or follow-up method of study consists of obtaining information (by interview, questionnaire or otherwise) about the habits or environment of a large number of people, none of whom are sick at the time this data is collected. The subjects are followed for a number of years and records are kept of all those who contract or die of a certain specified disease. The end results are then correlated with the facts gathered at the start of the study. It is generally agreed that from the scientific standpoint this is the method of choice. It altogether avoids most of the major difficulties of the alternative method and minimizes the effect of the remaining difficulties. Furthermore, it yields answers directly in the form most suitable for practical interpretation and application. However, the method has several serious disadvantages: for example, (a) it is unavoidably time consuming and may take as long as 20 years in some instances, (b) it is usually extremely expensive because of the large number of people who must be studied, and (c) it is extremely difficult to trace individuals for a number of years, particularly in America where people have a habit of moving around.

All of the studies of smoking in relation to human lung cancer previously described were based on the "backward method" of approach, although the exact details of procedure varied. Because of the known difficulties with this method, certain investigators, including myself, are not completely convinced as to the validity of the results, in spite of the fact that a number of independent studies conducted in more or less the same way led to more or less the same apparent conclusions. In particular I am not so concerned with the question of whether or not a cause and effect relationship exists between cigarette smoking and lung cancer as I am with the question of the degree of this relationship. From the practical standpoint it is the degree of the relationship which is important. If a finding that smoking increases the probability that an individual will develop lung cancer is to be used to save lives, then either people must be persuaded to give up smoking or the harmful ingredients must be discovered and removed from cigarettes. Neither is apt to be accomplished unless the relationship is found to be large.

For these reasons, in 1951, I began a study of smoking in relation to lung cancer by the more reliable but more laborious and time consuming follow-up method. The project was found to be



feasible only if it was confined to that segment of the population in which lung cancer death rates are highest. Even by limiting the study group to white males between the ages of 50 and 69, a minimum of about 200,000 person years of exposure to risk would be required to obtain reliable results and an even larger number would be required to make an accurate quantitative estimate of the association.

FIGURE 4

This is page 1 of the smoking questionnaire

Division No.:	Area No.:	Group No.:
Unit No.:	District No.:	Researcher No.:
Researcher's Name:		Case No.:

Dear Sir:

This is a study of differences in health between non-smokers and smokers. From time to time all sorts of claims have been made as to the effects of smoking on health. Many of these are poorly founded. We hope to determine statistically the effects of smoking in a group of men 50 years of age and over. Thank you for your cooperation.

American Cancer Society

Your Name..... Date.....

Address .....  
(Street) (City) (State)

How old are you? 50-54 ☐ 55-59 ☐ 60-64 ☐ 65-69 ☐

Read questions carefully before checking answers

A. Have you ever done smoking of any kind? Yes ☐  
No ☐

(If 'Yes') For how many years Enter No.  
have you smoked? of years

B. During your entire life Yes No  
Have you ever smoked at least as many  
as 5 to 10 packs of cigarettes? ☐ ☐  
(check Yes or No)  
Have you ever smoked at least as many  
as 50 to 75 cigars? ☐ ☐  
(check Yes or No)  
Have you ever smoked at least as many  
as 3 to 5 packages of pipe tobacco? ☐ ☐  
(check Yes or No)

If your answers to the 3 types of smoking in question B are all 'No,' we need no further information.  
However, if any answer has been 'Yes,' please answer the questions on the following pages.

FIGURE 5

This is page 2 of the smoking questionnaire. Pages 3 and 4 asked parallel questions on cigar smoking and pipe smoking.

CIGARETTE SMOKING

(If more than 5 to 10 packs of cigarettes smoked during your lifetime, complete this page on cigarette smoking habit.)

1. At the present time, how much cigarette smoking are you doing? (Check one)  
None ☐  
Smoke cigarettes once in a while but not every day ☐  
Regularly smoke cigarettes, but less than 1/2 pack a day ☐  
Regularly smoke from 1/2 to 1 pack of cigarettes a day ☐  
Regularly smoke more than 1 pack but less than 2 packs of cigarettes a day ☐  
Regularly smoke 2 or more packs of cigarettes a day ☐

2. If you do not smoke cigarettes now, how long has it been since you last smoked them? Enter Years  
3. How old were you when you first smoked cigarettes? Enter Age  
4. How many years altogether have you, or did you smoke cigarettes? Enter Years

5. Thinking back over the years you smoked, No. of Years  
For how many of those years did you smoke cigarettes occasionally, but not not every day? .....  
For how many of those years did you regularly smoke cigarettes, but less than 1/2 pack a day? .....  
For how many of those years did you regularly smoke from 1/2 to 1 pack of cigarettes a day? .....  
For how many of those years did you regularly smoke more than 1 pack but less than 2 packs of cigarettes a day? .....  
For how many of those years did you regularly smoke 2 or more packs of cigarettes a day? .....  
Total .....

Since a study on such a scale would be financially impossible using paid professional interviewers and follow-up workers, I decided to make use of the

large number of volunteer workers of the American Cancer Society. This required the development of a questionnaire which would be reliable under such conditions. About a dozen alternative forms were designed and tried in the field. The one finally selected is shown in Figures 4 and 5. It consists of a four page booklet, the first page asking general questions about smoking and the following three pages asking parallel questions about cigarette, cigar, and pipe smoking, respectively. Before use it was pretested by giving it to men to fill out without assistance, following which they were carefully questioned by highly skilled interviewers. The questionnaire answers were almost identical to the information obtained by interview. A final pretest conducted with volunteers indicated that the questionnaire could be counted upon to yield information sufficiently reliable for the purpose at hand.

A total of 394 counties in nine states were selected for the study on the basis of population, quality of medical facilities for the diagnosis of cancer, and the availability of volunteer workers. The states were New Jersey, New York, Pennsylvania, Michigan, Illinois, Wisconsin, Minnesota, Iowa and California. As a first step, researchers were recruited and meetings were held in which they were carefully instructed in what was expected of them. Each volunteer was asked to give smoking questionnaires to about ten men, preferably relations or friends whom she could easily trace for a number of years. In addition to verbal instruction she was also given written instructions. At annual intervals after the original questioning each volunteer was told that she would be asked to report on the men. On follow-up, the volunteers were only asked to report changes of address and to check whether each man was dead, alive or lost track of, and if dead, the date and place of death.

Between January and June of 1952 smoking questionnaires were obtained on 204,000 men, all in the age group 50 to 69. A sample was analyzed for self consistency of the answers and it was found that 90 per cent were completely self consistent and another 7 per cent somewhat inconsistent but still usable for some purposes. It is doubtful that more reliable information on this scale could have been obtained in practice by paid interviewers. Of those discarded, the major reason for unusability was that a few women and a few men outside of the age range were questioned.

The first follow-up was begun in November 1952. We had feared that many men would be lost to follow-up, but the volunteers succeeded in tracing 99.4 per cent of the men originally questioned. The second follow-up was started on November 1 of this year and early returns from 78 of the 394 counties seem to indicate that the second follow-up will be as successful as the first.

After reports are received from the volunteers, death certificate information is obtained from the health department on each man who died. If cancer is indicated anywhere on the death certificate, then we write to the doctor and/or hospital to obtain the best available information on the primary site of the disease and the basis of diagnosis. Insofar as possible we make a similar check on cases reported to have died of a respiratory disease other than lung cancer.

The information on smoking habits of the 204,000 men has now been coded and punched on IBM cards which will later be collated with cards containing information as to cause of death. The data will then be analyzed to determine (1) whether smoking is related to the overall death rate, and (2) whether smoking is related to death rates from specific causes, particularly primary cancer of the lung. When all the information is received from the present follow-up, we should have enough data to determine whether smokers in this age group have a higher overall death rate than non smokers as well as more detailed information as to the relative influence of such factors as type, duration, and amount of smoking. It is likely that another year's follow-up will be required before we can make a reliable analysis by cause.

The death rate during the first six months was lower than national figures for this age group. This was to be expected since people were not questioned who were seriously ill in the early winter and spring of 1952. For the same reason, the deaths during the first six months had a different distribution by cause than deaths in general. Judging from the experience of life insurance companies in such matters, these biasing factors should largely disappear after the first eight or nine months, but will be taken into consideration in the final analysis.

I wish that I could give you some hint as to the results, but the data so far collected has not warranted even a most preliminary analysis. Needless to say, I am as curious, if not more curious, than any-



one else except perhaps the owners of large blocks of stock in cigarette companies! A long delay in obtaining results is one of the prices we have to pay for the more reliable results obtainable by the long term follow-up method of study.

So far we have proved just one thing. It is feasible to conduct a large scale epidemiological study by the use of volunteers. This makes it possible to consider additional studies which otherwise would be out of the question because of financial limitations.

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## PHOTOGRAPHIC REPORT FORM

### State Department of Health Bureau of Laboratories Announces Change

On or about January 1, 1954 the Bureau of Laboratories of the Connecticut State Department of Health will initiate a new type of report form. Certain of the laboratory report forms, on which are furnished the results of laboratory examinations, will be of the photographic type. Such a form is printed on a special paper which allows the making of a photographic facsimile of the data sheet submitted by the physician with the specimen. This change will facilitate the reporting of laboratory findings and lessen the chances for error in transferring data to a typed report. The new forms will first be used in outfits for the collection of blood for syphilis; as experience is gained in the use of the new type of form it will be used in outfits for certain other types of specimens.

The syphilis history form has been redesigned to permit self addressing by physicians. The results of laboratory examinations will be entered on the same form and a facsimile of the completed form will be made and forwarded as the report to the physician. All information furnished by the physician on the history form will be reproduced and returned to him

on the photographed report form. The inclusion of this information should be advantageous to the physician.

The new type of form is designed to expedite the reporting of examinations. Its success depends upon the cooperation of physicians. It will be necessary for the physician to furnish his name and address and the name and address of the patient on the history blank in black or blue-black ink or with a heavy lead pencil if it cannot be typewritten. Water-blue ink, blue crayon or crayon lead cannot be used since they will not reproduce well. Neither can printed gummed labels carrying the physician's name and address, and affixed to the history blank, be successfully reproduced. When information is furnished in a manner which does not reproduce legibly, the post office may not be able to deliver the report. All information furnished by physicians and their assistants must be typed or printed in a legible manner. A complete return address must be placed in the space provided as this address will be the one reproduced for mailing.

## LAYMAN AND STAFF

GEORGE S. STEVENSON, *New Haven*

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The Author. *President, Board of Directors, Grace-New Haven Community Hospital, New Haven, Connecticut*

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### SUMMARY

An effective and agreeable relationship between the Board and the Staff depends upon a mutual understanding of their respective duties and responsibilities. Some of the areas can be clearly demarcated, but many so overlap as to require a constant process of consultation and decision. At Grace-New Haven Community Hospital the latter field is primarily under the care of the Joint Conference Committee in which representatives of the Medical Staff and of the Board of Directors can sit around a table with the Director of the Hospital and the Dean of the Medical School and apply themselves to any and all problems of mutual interest and importance. Among the problems presented are those which arise at two previous meetings, one a meeting of the Executive Committee of the General Staff and another the Executive Committee of the General Staff meeting with the Executive Committee of the University Staff. Opportunity is always open for the Joint Conference to sit with any of the above-named committees or even with the full Board on any matters calling for such further deliberation. A recent step forward has been the formal organizing of the Staff as a whole with a President and other officers chosen by ballot by the entire membership. By this means the mechanism is provided by which the entire Staff can think collectively and make its thoughts known. The unanimous choice for the first President was Dr. Daniel F. Levy.

NO LAYMAN can accept any part of the responsibility for the conduct of a hospital without experiencing an emotion that is akin to awe. He is sure to search his mind and his heart for the answers to many questions. The first question he will ask himself is broad enough to touch upon all the others. It is this: How should a layman behave around a hospital? How can he know his place; and, while being sure that he fills it, can be equally careful not to step out of it?

He will probably start by generalizing, and will find that there are two areas for the application of his efforts. While the areas overlap in countless ways, they may, for our purposes, be treated separately. One is the area of practical business. It includes the providing of buildings and equipment, most of which must come from benefactions; the preparation of budgets and a readiness to make changes in them as conditions may change; the fixing of patient charges that will be sufficient to pay the bills and yet bearable to the public; constant thought to the selection of priorities for the future developments that are essential to progress. You might call this the area of the balance sheet. For all these responsibilities the collective judgment of men experienced in business affairs ought to be adequate, provided it is applied with an understanding of the principles involved in the other area.

### THE PHYSICIAN'S PART IN THE HOSPITAL

The other area is the supreme test of hospital statesmanship. It lacks the definiteness of the figures in a balance sheet or in a statement of income and expense. Yet in its very indefiniteness lies its greatest opportunity and strength. Here at Grace-New Haven we have a superb assemblage of the best minds





GRACE-NEW HAVEN COMMUNITY HOSPITAL

produced in our society, with the understanding hearts essential to guide and fortify them. Each, thank God again, is himself. I allow no one, within my hearing, to speak of doctors as "prima donnas." Nor do I allow anyone to call them temperamental, if the inference is that they differ in that respect from other sensitive, highly trained individuals of strong character.

I need not remind you that doctors start as strong men. Most of them have decided during their early years what they want to do. Such youthful decisions are seldom based upon the material rewards that may be expected or upon the position in society that may be attained. Most youthful decisions are based upon idealism. Many a youth has had as a hero one doctor in whom he sees all the qualities he would like to have as his own. His stamina is proved and his character confirmed as he persists through the long,

arduous years of premedical, medical, and clinical training. Then he goes on his own.

Nor need I remind you that a doctor has only himself. He has only his competence and his time. Of course he is individualistic, but he is so in the very finest sense of the term. Of course he is self-confident, but his self confidence is founded upon his never ceasing efforts to know and practice the latest and best in his profession. The volume of periodical literature issued by and for the medical profession, and studied faithfully, exceeds that of any other profession or vocation. And the exchange of ideas and methods among doctors is freer, and franker, and more lacking in self interest than among any other group.

And I do not need to describe to you the kind of life a doctor accepts. Assuming the responsibility for the health and life of every patient, he carries



that burden twenty-four hours a day. His patients absorb his thoughts. His mind is never away from them. Men in other pursuits are seldom called from their beds at two o'clock in the morning to attend a crisis, and after the briefest sleep, if any, be on hand at the usual time to go through a long day of sustained effort. Contrast the lawyers, contrast the men who work in banks!

#### THE LAYMAN IN THE HOSPITAL

Now, in this specialized, demanding, and truly exalted world of the hospital, what can a layman do to help?

Under the law and by the accepted canons of society, the Board of Directors carries the ultimate responsibility for the conduct and well-being of a hospital such as ours. For the discharge of all its duties, both expressed and implied, the Board of Grace-New Haven is organized in the following pattern:

We operate under a charter granted in 1826 and brought up to date by many amendments. The directors at present number ninety-six, a group too large to perform administrative work or to legislate on any but the broadest policies. Its size, however, is highly useful in that it represents a cross section of the whole community, giving a great diversity of points of view and making sure that the voice of the community can always be heard. The Board meets regularly five times a year—on the first Fridays of October, December, February, April, and June. Special meetings are held when necessary.

For administrative purposes, and for detailed legislation within the framework of the broad general policies, there is an Executive Committee, made responsible, under the By-Laws, for the management of the institution. It now numbers eleven, and its members are largely the chairmen of the special purpose committees—Finance and Budget, Investment and Trust Administration, Personnel, Medical, Nursing School, Building and Maintenance, Public Relations. It meets at least once a month. At its meetings are brought to focus all the activities of the Hospital—for report, discussion, and action. Its powers are large, in order to avoid harmful lags in decisions. The director, of course, is always present to make report upon the general state of the hospital, with all necessary details, and to transmit faithfully the points of view that you of the staff may have expressed to him. I don't see how he encompasses it all, but he does.

The members of the Executive Committee are all laymen. We laymen have a great fondness for blueprints. They seem to give us a feeling that we know where we are going and can stick colored pins in periodically to mark our progress. When a layman has joined a hospital board and has got over his first surprise at being chosen for so honorable a position, he is inclined to call for the blueprints. That is good provided he is gently led to see that no blueprint can cover more than a limited part of the activities for which he has accepted a responsibility. The limited part includes such matters as the providing of physical facilities, on what is likely to be a steadily expanding scale; responsibility for the operating budget; repairs and maintenance; the purchasing department; the management of endowment funds; the philosophy that rules personnel relationships; public relations.

All these matters are blueprintable for the layman because they are not alien to the ordinary processes of his own business. In them he feels at home, and falls easily into his committee assignments.

But I don't have to tell you that there is more to it than that—ininitely more—and the way in which it is done can make all the difference!

#### MUTUAL UNDERSTANDING BETWEEN GOVERNING BOARDS AND PHYSICIANS

One of the problems confronting the voluntary hospital—and there is little excuse for it—is the lack of development of mutual understanding between governing boards and the physicians practicing in the hospital as to their separate and mutual responsibilities and their relationship, each to the other. Doctors, with their high duty of jealously guarding their rights and privileges in regard to the medical care of their patients, must see to it that no one else will try to tell them how to practice medicine. Coupled with that fact is the one that governing boards of hospitals are becoming more aware of their obligations and duties, and are taking far greater interest than ever before in the quality of medical care that is practiced in the institution over which they have jurisdiction. The concern of the layman over the type of medical care being practiced in the hospital and the proper and necessary attitude of the doctor that the doctor alone is the judge as to the type of medical care must not, and need not, be allowed to lead to conflict.

It is easy to understand how conflict has sometimes developed when one looks at the historical evolution of the hospital. Originally, the hospital was organized and managed by the individuals caring for the sick. The individuals responsible for the running of the hospital also were the ones who cared for the patients. As hospitals grew in size and complexity, a division of labor gradually developed, and the physicians concerned themselves more with the care of the patients within the hospital, with the actual management of the hospital falling more and more to lay individuals, and lay groups. As hospitals have increased in size and complexity, the community has been called upon to assume a greater responsibility for their management, and in the vast majority of the voluntary hospitals as we know them today the governing body is made up of representative laymen in the community with few, if any, physicians being formal members of the Board.

#### THE SPECIALIST IN THE HOSPITAL

With this increase in the size and complexity of the hospitals, there has developed a concentration around the hospital of many of the so-called diagnostic and specialized therapeutic services; and groups of medical specialists—Radiology, Anesthesiology, Pathology, and Physical Medicine—have centered their activities in the hospital. Because of the full-time nature of these specialties, and because so much of their work has become very closely associated with hospital service, many of these medical specialists have come to be on a salaried basis as contrasted to the customary fee-for-service reimbursement of their professional colleagues in the clinical fields. As a result, physicians in certain specialties are now employees of the hospital. With the hospital board being largely made up of laymen, and with many of the hospital administrators being laymen, a justifiable concern has been expressed by physicians that they might be thought of, and treated, as salaried employees of a lay corporate group who would try to direct their medical activities.

It is easy to understand why members of the medical profession should have felt a certain uneasiness in their association with a hospital which is employing some of them on salary and is setting up rules and regulations for all, with the top people with whom they deal being laymen. Consequently, it is sometimes said that laymen are telling the doctors how to practice medicine, or are on the way to telling them.

My observation is that the trustees of the voluntary hospitals are becoming more and more aware of their obligations. They realize that they have a moral, as well as a legal, compulsion to see to it that all things are in order in the hospital, and that this includes not only such matters as the preparation of the food, the billing of the patient, the nursing service, but also the quality of the medical care that is rendered to patients.

It follows that the board of directors, under its legal and moral compulsions, is called upon to carry the responsibility for the selection of the physicians who have privileges in the hospital. The board must take the position that membership on the staff is a privilege to be granted, not an obligation to be enforced, and that the community looks to the medical members of the staff with confidence, inasmuch as they have had the stamp of approval placed upon them by the hospital itself. Consequently, the board of directors must be certain that it keeps faith with the community by the fitness of its appointments.

The lay member of the board, however, has to realize that medicine is a highly specialized field, and that he is in no position himself to pass judgment on the training and qualifications, or the type of medicine practiced by the individual physician. Consequently, he has to meet his obligation to the community and to the hospital by delegating responsibility. The layman carrying the responsibility, both legal and moral, but with a realization of his limitations, has no choice but to delegate matters requiring medical judgment to the best medical men that he can find.

The board, by delegating its responsibility to the medical chiefs, also gives to those chiefs the necessary authority. The chief of staff, or the chief of a specific professional service, is told that he is responsible for the medical care going on under this jurisdiction—that he is expected to see to it that his colleagues are properly selected and are functioning within the limits of their ability. He could not carry this burden if he were not clothed with sufficient authority to enforce such requirements of good medicine as seem to him to be indicated.

This may possibly be one of the greatest contributions that the voluntary hospital with its lay board of directors has made to the improvement of medical standards and medical care in this country. None of us is eager to throw his weight around or to tell his colleagues how to do their work. Each of us



would rather do a good job himself, and allow his colleagues to do theirs in their own way.

#### SELECTION OF MEDICAL CHIEFS

Now the hospital, by its very organization, sets up a board of directors which has responsibility for medical care and which, in turn, establishes a group of medical chiefs. These chiefs realize that one of the necessities of their positions is that they will accept this supervisory responsibility, being assured that they will be supported by the authority of the board in enforcing the necessary regulations. As a result, hospitals are able to limit the type of work that a physician does, enforcing rules and regulations as to the practice of medicine, and can thereby steadily improve the quality of medical care. However, it must be emphasized that this is not done by the layman telling the doctor how to practice medicine, but by the layman telling carefully selected physicians of superior ability that they have the responsibility and that they have the authority. The hospital sets up the framework by which the physicians are able to regulate themselves. This is extremely important.

Starting at the apex, the delegations of responsibility and authority broaden out steadily and, we hope, with uniformity. The main reliance is upon the chiefs, and upon their shoulders fall the heaviest burdens. The hospital, by this arrangement, can be administered as a coherent whole, with the necessary precautions as to the selection of the physicians admitted to privileges and with a good assurance that each functions within the limits of his ability, playing fair with all his colleagues and with the

spirit and practices of the institution as a whole.

How shall the chiefs be selected? It is an old, old question, and some of you have allowed me to know your thoughts on it informally in the past. I myself do not regard selection by ballot, within the service, as desirable. The most dependable guide to the right selection would seem to me to be the total ensemble and integration of the opinions of those whose judgments have been found, within the circles in which they move, to be the calmest, the most objective, the most unbiased, the most disinterested, and therefore the weightiest. In assembling and weighing these opinions I prefer the greatest informality possible. The day-by-day rubbing together of minds and personalities leads naturally to conclusions that cannot be far wrong. Whenever a selection looms in the future I favor a good deal of freedom in conversation about it, provided every effort is made to preserve an atmosphere free from invidiousness, and provided those charged with the duty of making the final decision keep themselves solemnly aware of the necessity of exercising the utmost of judicial fairness.

No graver duty can ever confront the board of directors than the selecting of the chiefs.

I have given you my thoughts as clearly as I could. If they are in error at any point, you will know how to set me right. Wherever I may be correct your approval will give me courage.

We laymen are trying to help. Humbly we hope to follow the great medical tradition of learning from each day's experience how to do better the work that the next day will bring.

## THE WHY OF HOSPITAL CHARGES

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### SUMMARY

The problem of hospital operating costs is not new but it is causing increasing concern. The cost of hospital care today is compared with that of 1940 and it is pointed out that inflation is not the sole reason for this increase. Improvement in hospital care has contributed to the increase in cost. The per cent of the cost of the average stay in the hospital to the per capita income showed very little change in 1952 from 1940.

The increase in payroll is a very large item in the increase in the cost of hospital care. Student nurses now provide one-half as much free labor as 12 years ago. Although the cost of living has almost doubled in 12 years, payroll rates per employee are almost  $3\frac{1}{2}$  times as much. Inefficiency in hospital administration is refuted. Hospital charges cannot be compared with hotel charges. The diminution in the amount of endowment a hospital possesses directly affects the size of the patient's bill. The catastrophic illness poses the most difficult problem to hospital and patient alike.

ONE of the most important administrative subjects in all hospitals today is the need for improvement in the public's understanding of charges for hospital care. The problem is not new. I can recall distinctly, in the late 1930's, bitter complaints from many concerning the exorbitant charge of \$5 per day for board and care in a two bed room. To illustrate just how old the problem of hospital operating costs is, a quotation from the superintendent of Hartford Hospital in his Annual Report of 1881 is offered. "The institution is increasing its scope and usefulness, conditions always involving increased expenses." Along the same lines we find a statement of the director of Hartford Hospital in his Annual Report of 1936, which reads, "With rapid advances

being made in medical science comes a corresponding increase in the cost of hospitalization, due to the fact that modern medicine requires more expensive equipment, more scientific treatment, and more bedside care." Add to that statement the effect of inflation in our economy, date it 1952, and we have a summary of this presentation.

There is great and widespread concern among hospitals on the problem of costs. This concern is not only with sound and efficient operation, but also with public reaction and better acceptance of the seemingly high cost of hospital care. If hospital care were not such a vitally important part of community welfare, two simple alternatives might be considered by hospital governing boards and medical and surgical staffs—reduction of service or curtailment of quality. As you well know this expediency would receive very little consideration from the governing board or the medical and surgical staff of any first class hospital. Even if this alternative were adopted, the public would soon let their feelings in the matter be known.

Patiently and accurately informing the public what it gets for its hospital care dollar is the most complex public relations problem facing us today. It is here that the medical and surgical staff of a hospital can be of real help to their hospital and themselves. We are walking down this road together. What is good for one is good for the other and, best of all, what is good for both of us is good for the public. It is a well known fact that the public usually gets what it wants through legislation. We must take the time and make the effort to change the thinking of those who are unfairly critical of hospital charges. The public is well aware of increased costs as the result of inflation for all goods and services purchased by him. But by no means is inflation the only reason that hospital costs are so much higher than they were prior to World War II. There have been tremendous changes in hospital care since 1940. The shortened stay, early ambulation, new and improved techniques, more and better treatments, add-





HARTFORD HOSPITAL

ed services, more personnel and more highly trained personnel, are major factors that contribute to the increased cost of care. It is your and my job to help the public understand that good hospital care costs money and that the charges are consistent with the services. There is no incentive for the hospital administration to set the charge for services so that income is in excess of operating expenses. The hospital is only the middleman who must collect enough money from those who use the hospital to pay those who supply services or material things to the hospital.

Our trouble stems from the comparisons that are made between the charges for service in some previous year to the current year. That is quite understandable. Comparisons are the only base one can find when the matter is viewed superficially. Why should the average for all-inclusive care in 1940 be \$6.05 per day and in 1952 the charge for care in the same hospital is \$22.97. It is conceded that inflation might cause the \$6.05 to become \$12.10 but where in the world does the other \$10.87 go? A very good question and, with minor variations and some colorful adjectives added, a very common one. I would like to dodge this question, not because of fear that the differential could not be satisfactorily explained. To do that would be very easy but it would complicate this presentation because of the adjustments

which would have to be made to compensate for the difference in the number of days a patient now stays in the hospital as compared to 1940. Furthermore, the charges about which we are concerned are not for a day in the hospital but a stay in the hospital. I will attempt to explain the difference in the average cost of \$70.18 for a stay in the hospital in 1940 compared to an average of \$181.87 for a stay in 1952.

Before proceeding in that direction let us examine the psychological factors involved when dealing with the public in the matter of a hospital bill. Generally speaking we are in a business offering services which the customer does not want. It is usually his misfortune that causes him to need our facilities. This fact sets up an unnatural business relationship about which it is difficult to do anything. Altogether too often the funds to pay a hospital bill are not on hand and the family budget must be rearranged to accommodate this unwanted intruder. Even if one has the funds on hand to pay a hospital bill it is easy to understand why it would be preferable to spend such reserve funds for a long dreamed of vacation, or toward the cost of replacing the family car.

Now to the "why" of these so-called high hospital charges. Since high is a word that only has meaning when used relatively, we must find a year

in our history when hospital charges were considered low. We all know that hospital charges were never considered low, so it seems logical that we find the year in modern times in which the patient paid the least amount for an average stay in the hospital, taking into consideration the relative value of the dollar in that year. On this basis we have determined that the year 1940 represented the "best buy" in hospital care for the average patient. In this year he spent the least amount of constant value dollars for an average stay in Hartford Hospital. With 1940 as our base year for comparative purposes, Table No. 1 is offered to illustrate just how high our costs were in 1952, and the effect of these costs on the annual income of citizens of the State of Connecticut. The two important points shown on this table are: (1) the proportion of the average citizen's income to the average hospital cost per stay is slightly higher in 1952 than it was in 1940; and (2) the average cost per stay in constant value dollars is approximately \$50 more in 1952. In the matter of the first point, I think that it can safely be assumed that the present common policy of employers providing, free of charge, Blue Cross or other hospitalization insurance to their employees, would cause the 1952 proportion to drop to less than 9 per cent. From this it would seem safe to state that the cost of the average hospital stay in 1952 does not require a disproportionate part of the average citizen's income. Just in case the impression is created that an individual pays an average of 9 per cent of his income annually to hospitals in Connecticut, I would like to point out that, statistically, each person in the State goes to the hospital as a patient only once every eight years. Explaining the reason for \$50 difference in point number 2, previously mentioned, is not quite so simple. In Table No. 2 we have tabulated some information which indicates that a stay in Hartford Hospital was quite different in 1940 than in 1952 in terms of services rendered. I am unable to determine just how much of the \$50 which we are looking for is represented by the increases indicated in this chart but it is, no doubt, substantial since these services are all major items in a hospital operating budget. Another item of considerable consequence in this picture is the difference in our present policy of having student nurses work on patient floors an average of 24 hours per week instead of 45 hours per week, as was the custom in 1940. In 1952 our student nurses worked on patient floors an average of 6,000 hours per week. In 1940 this same group worked an average

of approximately 12,000 hours per week on patient floors. This is a difference of 6,000 hours which was free labor in 1940 and must now be paid for at the rate of about \$1.25 per hour.

TABLE No. 1  
HARTFORD HOSPITAL  
FINANCIAL ANALYSIS AND COMPARISON OF AVERAGE COST PER  
PATIENT STAY IN HOSPITAL

	1940	1952
Average cost per day per patient.....	\$ 6.05	\$ 22.97
Average length of stay, days.....	11.6	8.0
Cost per stay of each patient.....	\$ 70.18	\$ 181.87
Relative value of dollar (purchasing power) 100		53
Cost of stay in 1952 dollars.....	\$132.30	\$ 181.87
Annual per capita income in Connecticut.....	\$780.00	\$1,942.00
Per cent of cost of average stay in hospital to per capita income.....	9.0	9.4

TABLE No. 2  
COMPARISON OF SOME SPECIAL SERVICES RENDERED  
HARTFORD HOSPITAL

	TOTAL VOLUME		UNITS OF SERVICE PER 100 PATIENTS	
	1940	1952	1940	1952
Laboratory exams (excluding urinalysis) .....	54,272	174,415	259	538
Flasks of I. V. solutions used .....	23,500	95,166	112	294
Blood transfusions .....	1,441	6,454	7	20
Physical medicine treatments .....	3,999	26,942	2	8
Oxygen used (cu. ft.).....	685,000	3,055,425	3,264	9,429
X-ray exams .....	10,872	32,175	52	100
Pharmacy purchases .....	\$18,372	\$153,039	\$87.50	\$472.00

In Table No. 1, it is pointed out that the relative value of the dollar was shown to be \$1 in 1940 and 53 cents in 1952. It was this fact that we used to correct the average cost per stay from \$70.18 to \$132.30 so that the dollar values would be constant in comparing 1940 to 1952. If we were to adjust our average payroll rates in 1940 in the same manner, we find that our average rate per hour per employee would be 80 cents as compared to 42 cents per hour paid in 1940. If Hartford Hospital paid an average of 80 cents per hour to its personnel, an average stay in that hospital would cost less than \$132.30 in 1952.

Inflation, as we meet it in our day to day living, is thoroughly understood by all of us. However, in this hospital inflation and the highly competitive labor



TABLE No. 3  
COMPARISON OF WAGE RATES PAID TO PERSONNEL IN  
HARTFORD HOSPITAL  
(Adjusted for value of maintenance provided in 1940)

	RATE PER HOUR		MULTIPLIER FACTOR DIFFERENCE
	1940	1952	
Staff nurse .....	.40	1.40	3.5
Male aide .....	.31	1.10	3.5
Clerk typist .....	.28	1.10	3.9
Kitchenman .....	.23	1.05	4.5
Maid .....	.26	.95	3.6
Cashier .....	.31	1.25	4.0
Laundry worker (female).....	.32	1.05	3.3
Elevator operator .....	.31	1.10	3.5
Laboratory technician .....	.42	1.32	3.2
	—	—	—
Average all personnel.....	.42	1.43	3.4

situation in Hartford causes difficult fiscal problems. Prior to 1941, pay to hospital personnel was substantially below pay to equivalent personnel in commercial enterprise. In 1940 it was an easy matter to staff a hospital with effective personnel at substandard rates simply because a job in the hospital was better than having no job. This matter of our payroll is the heart of the problem. Even though the so-called cost of living has almost doubled since 1940, our payroll rates per employee are almost  $3\frac{1}{2}$  times as much now as they were then (see Table No. 3). Add to this the lost 6,000 student nurse hours previously mentioned and you have a problem that is difficult to do anything about. This is especially serious since our payroll represents about 65 per cent of our total expense.

It is sometimes said that the real reason for the high cost of care in a hospital is inefficiency in its administration and supervision. This is only an opinion usually substantiated by isolated instances that are relatively minor. To disprove the validity of this statement in a scientific manner would be impossible. Since this is the case we must again resort to making a comparison to judge the inefficiency of hospital management as compared to that in commercial enterprise. It could be assumed that if anyone could operate an efficient hospital, a commercial organization whose name has been synonymous with efficiency in industry would certainly be the most likely to do so. The Ford Motor Company, a corporate giant in the highly exacting and competitive automobile manufacturing business, is an influencing force in the affairs of the Henry Ford Hospital in

Detroit. A cursory examination of the basic statistics of that hospital reveals that they are "enjoying" essentially the same situation we have in Connecticut, namely, it requires approximately two full time personnel to provide for the hospitalization of one patient for one day. Like most hospitals in Connecticut, approximately 65 per cent of the total expense of operating Henry Ford Hospital is payroll expense.

We have often heard that hospital charges are certainly not fair when they are compared to the charges made by a hotel. Why should a hospital charge \$22 per day for care when accommodations and meals could be obtained in an American Plan hotel for considerably less? Why should a hotel and hospital ever be compared, might be a fairer question. The only similarity between the two facilities is that they both provide places for people to sleep and eat. With this as the only function common to both institutions it is difficult to relate the charge for services rendered. However, by eliminating the cost of all functions in the hospital that are only found in hospitals and never in hotels (i.e., nursing care, x-ray laboratory, operating rooms, medical records, etc.) we find a rather interesting fact. The cost of providing and maintaining non medical services, including food served to the patient in bed at Hartford Hospital in 1952, is only \$5.75 per day, approximately 25 per cent of the total cost per day.

A final important point to consider is the difference in the effect of our endowment income on the patient's bill. In 1940 Hartford Hospital endowment income was \$225,683, or the equivalent of \$10.80 per patient. We have previously pointed out that the average cost of caring for a patient in 1940 was \$70.18 but it was only theoretically necessary to charge him \$59.38, since the difference between cost and charge could be made up with endowment income funds. In effect, we were able to discount his bill 15 per cent below the cost of rendering the service. In 1952 Hartford Hospital endowment income was \$284,612 or the equivalent of \$8.78 per patient. The cost of caring for a patient in 1952 was \$181.87 so endowment income enables us to charge him an average of \$173.09 or only 5 per cent less than the cost of rendering the service.

I wish it were possible to prove that increased expense caused by our requiring more personnel, doing more laboratory work, using more oxygen and blood, more pharmaceuticals, etc., was well worth

while, viewing the matter from the patient's position. This cannot be done with factual reasoning so Table No. 3 is offered as the next best thing. We all know that the result is the work of many people, government and both commercial and non profit organizations. We can assume, I believe, that much of the improvement in the mortality rates in this country is the result of what is done for a patient when he is in a hospital. Unfortunately, what is done for a patient in a hospital does cost money, more money than some can afford, but on the basis of information in this table it seems that even though hospitals were to play only a small part in the picture, the money is well invested.

In concluding I would like to offer the opinion that we in hospitals, both in administration and physician staff, need not be concerned with the burden caused by hospital bills in those situations where the circumstances are average. That is, a person of an average financial situation who is responsible for an average size hospital bill, an average number of times during a ten year period, should not be the subject of our concern. It is interesting to note that in a family of four, payment of the average hospital bill once every two years (statistical average) for one member of that family could be paid with the amount of money which would be spent by that family for slightly more than one pack of cigarettes per day. We should be very concerned

TABLE No. 4  
MORTALITY STATISTICS—UNITED STATES

AGE GROUP	DEATHS		PERCENTAGE DIFFERENCE BETWEEN 1940 AND 1949
	PER THOUSAND OF POPULATION		
	1940	1949	
Under 1	54.8	34.0	38.0
1-4	2.9	1.5	48.3
5-14	1.0	.6	40.0
15-24	2.0	1.3	35.0
25-34	3.1	1.9	38.7
35-44	5.2	3.7	28.8
45-54	10.6	8.8	17.0
55-64	22.0	19.1	14.2
65-74	48.2	43.4	10.0
75-84	110.9	94.5	14.8

with the problem of the man whose situation is substantially different from the average so as to cause a financial catastrophe in his life. Unfortunately, the funds available for most hospitals to be of help are so limited, only the most unusual cases in a desperate set of circumstances can be offered direct assistance. It is in this area that all of us who are interested in the financial aspect of hospital care should direct our serious thinking.

#### SOURCES OF STATISTICAL DATA

Statistical Abstract of the United States—1952.  
American Hospital Association—*Hospitals Magazine*.  
Hartford Hospital Records.



## A CENTRAL SCOTOMA OCCURRING DURING SYSTEMIC CORTISONE THERAPY

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**D**UE to the present use of cortisone as a therapeutic agent the following case history seems of importance. The widespread use of the drug and the incomplete knowledge of its physiological action makes it imperative that further clinical information becomes available.

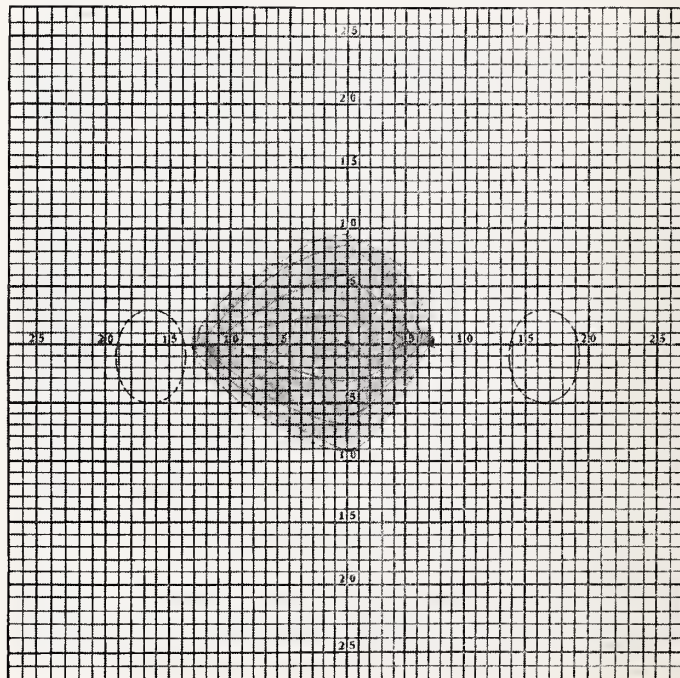
The patient, a 37 year old male was seen in September of 1951 complaining of ocular fatigue from continued close eye work. At this time a routine ophthalmological examination was performed. He had a mild degree of latent hyperopia at this time but was otherwise in excellent ocular status. His acuity was 20/20 plus in each eye without correction, visual fields were full and no pathology was noted either by slit-lamp examination or with the ophthalmoscope. The patient was next seen on January 10, 1952 with a complaint of failing vision in the left eye for the past five days. Examination at this time revealed the following: O.D. 20/20 with no pathology noted in fundus. O.S. 20/200; the left macular area appeared slightly raised and surrounded by a greyish ring. With the giant binocular scope it was definitely raised and edematous. A central scotoma existed (see chart). The patient was on 100 mgms. of cortisone acetate daily for osteoarthritis at this time.

In view of the above findings the following history is of interest: In 1940 the patient suffered an attack of acute tonsillitis associated with definite rheumatic joint symptoms. The arthritic symptoms continued until 1942 and at this time his tonsils were removed followed by a definite relief of the joint symptoms. In 1945 his appendix was removed. In 1949 he began to have some abdominal pain and distress after eating and a G.I. series was done which revealed a sub-acute gastritis and functional pylorospasm. A bland diet and rest seemed to afford adequate relief and recovery at this time.

Subsequently, the patient's physician was consulted in September of 1951 because of epigastric pain radiating into the left chest region. The severity of these attacks warranted hospitalization, which was done in October 1951. A general work up at this time was undertaken with the following findings: Epigastric pain, spasmodic in nature, with increasing severity and frequency. Some nausea was present during the attacks and there was no indication of any known food sensitivity. Physical examination revealed a well devel-

oped male with no apparent physical defects. Examination of the abdomen revealed no masses or areas of tenderness. The cardio-vascular system was quite healthy and the EKG was normal. Chest x-ray was negative, and G.I. series and gall bladder x-ray examination were also negative. The blood picture was normal and a myelogram of the spine showed no vertebral displacement. X-ray of the spine showed a definite cervico-dorsal arthritis, which was thought to be severe enough to account for the symptoms.

Accordingly, the patient was placed on a daily oral dose of 75 mgms. of cortisone acetate. This was on October 20, 1951. The patient was first seen complaining of blurred vision in the left eye on January 10, 1952, at which time he was on the same daily dosage of cortisone. The vision had been blurred since January 5, 1952 and by the history was getting progressively worse. Examination of the fundus of the right eye was negative. However, the macular area of



10 mm. red test object used at one meter standard illumination both eyes

O.S. 20/200 slow

V.A. O.D. 20/20 slow

cooperation good

O.S. central scotoma relative

the left eye showed definite pathologic features. The macula appeared slightly raised and was surrounded by a dull gray ring as examined by the giant binocular ophthalmoscope. A definite central scotoma of approximately ten degrees existed at this time. This was not an absolute, but a relative scotoma. Accordingly, a tentative diagnosis of acute macular chorioretinitis was established.

Another examination was done on January 12, with essentially the same findings. Subsequent examination on January 18 and January 25 revealed that the visual acuity had decreased to 20/400 in the left eye. The right eye remained unchanged, both subjectively and objectively. On February 1 it was decided to stop the cortisone therapy, the ocular condition having remained the same as when seen previously. On February 8 there was definite subjective improvement, the visual acuity to have increased to 20/35 and the central scotoma to have almost disappeared. Examination on February 22 showed vision to be 20/25 with no field changes noted.

On March 7, 1952 the vision was 20/20 and the subsequent weekly examinations showed no change. Examination on May 3 showed the visual acuity to be 20/20 with full fields. It was again examined on November 9 and again the vision was 20/20, and the fields normal.

#### SUMMARY

The above case has been presented because of the simultaneous appearance of an acute macular lesion of the left eye during cortisone therapy. The rather acute onset of the lesion combined with rapid disappearance following the removal of cortisone therapy points to an interesting if ill defined relationship. Obviously it is difficult to ascertain the true place of cortisone as an etiologic factor in this instance. Further investigation along these lines may supplement and clarify such relationship.

## INTRARENAL VASCULAR THROMBOSIS

### Case Presenting Clinical Picture of Nephrotic Syndrome

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#### SUMMARY

1. A case of intrarenal vascular thrombosis is presented occurring in an 8 day old infant.
2. This case is remarkable because of its early onset and prolonged course, chemically and clinically resembling nephrosis, and preservation of adequate excretory function as determined by I.V. pyelogram.
3. It is suggested that the kidney and lung are the seat of thrombus formation because in disease states with sludging of blood the vessels of these organs may be quickly occluded.

according to Kobernick's<sup>1</sup> statistics from experiences at Children's Memorial Hospital is 0.37 per cent. Other figures quoted by this author vary from .027 to 2 per cent of total necropsies. There has been a reawakening of interest in this syndrome, due in part to the possibility of surgical cure in promptly diagnosed cases<sup>2,3</sup> and also attributable to stimulating reviews by Barenberg,<sup>4</sup> Fallon,<sup>5</sup> Zuelzer,<sup>6</sup> Kobernick and others.

The common characterization of this syndrome pictures an infant debilitated and dehydrated from diarrhea or (less often) some other extrarenal infection who suddenly develops shock, anuria, or oliguria, albuminuria, hematuria and possibly palpable renal mass. Renal function fails quickly as demonstrated by rising NPN and a failing concentrating capacity on excretory urography. Venous thrombosis in other organs, particularly the lungs, is often an associated finding.

The clinical picture of nephrosis with intrarenal vascular thrombosis has been infrequently described.

**I**NTRARENAL vascular thrombosis in infancy is a rarely diagnosed and infrequently occurring condition. In terms of autopsies performed its incidence



Derow<sup>7</sup> reported a 15 year old boy with progressive thrombosis of the inferior vena cava, renal and portal veins whose clinical picture resembled nephrosis. Nordvall<sup>8</sup> reported a two week old infant who developed generalized edema and anuria following gastroenteritis and on autopsy was revealed to have many renal hemorrhagic infarctions. Edema was noted to exist in one of the cases described by Zuelzer.

In the case which is reported here a clinical and chemical picture of the nephrotic syndrome was present in an infant who developed symptoms in the first week of life following mild impetigo.

S. K. was the product of a normal second pregnancy and she weighed 5 lb. 6 oz. at birth on December 29, 1950. Delivery was normal. The baby breathed spontaneously but was cyanotic out of oxygen and required frequent suctioning. Complete blood count and Hb. were normal but 22 nucleated RBC were noted. Subsequent counts did not reveal any anemia and there was no organomegaly or jaundice.

On the second day the baby took the proffered water poorly and temperature rose to 100.6. 50 cc. of normal saline with  $\frac{1}{2}$  vial of Alidase was given in the intrascapular area and the temperature returned to normal. On the third day the infant took feedings well, could be out of oxygen without distress but a few blotches were noticed on the face and forehead. These became pustular blebs which on the 5th day had begun to dry. The weight was 5 lb. 12 oz. and there was slight edema in the intrascapular area.

On the second day after discharge from the hospital the mother noticed that the baby's ankles appeared to be swollen and the swelling gradually increased, progressing caudad from the feet during the next three days. The baby was seen at home four days following discharge from the hospital and there was 4 plus pitting edema extending to the groin. A systolic murmur not previously heard was noted over the precordium and no femoral pulsation was palpable (? because of edema in groin). The skin infection had entirely cleared. The child was admitted to the hospital with a diagnosis of edema of the newborn and congenital heart disease, possible coarctation of the aorta.

Physical examination on admission revealed a well developed, well nourished baby with edema of both lower extremities. There was a healing rash over the forehead and the side of the face. Head size was normal but a systolic murmur could be heard over the precordium. No femoral pulse could be felt.

The admission laboratory data revealed 3 plus albuminuria, 6 to 8 red cells, 10 to 15 white cells per high powered field. The red blood count was 4.3 mill., Hb. 14 Gm., white blood count 15,300 with a normal differential. The urea nitrogen on admission was 36 mgms. per cent., blood CO<sub>2</sub> was 22.5 ml. equivalents, the serum chlorides were 108 ml. equivalents. The blood protein was 4 with a 1.2/2.8 albumin globulin ratio. On the second day in the hospital the edema continued to increase and there was edema of the subcutaneous tissues over the abdomen, the tissues of the chest and the dependent

side of the face. By the third hospital day free fluid could be detected in the abdomen. A tentative diagnosis of intravascular renal thrombosis was then made. An IV pyelogram was attempted but the dye was so rapidly excreted into the bladder that good visualization of the renal structures was not possible. However, the dye could be traced from the renal plexis and through the ureters, indicating fairly rapid and complete excretion with adequate concentration. A repeat intravenous pyelogram was attempted and the left renal pelvis and calices were well visualized and considered to be normal.

The baby was fed salt free milk and given repeated infusions of concentrated plasma and whole blood to combat the rapidly progressive anemia and hypoproteinemia. By the 13th hospital day the edema was much more pronounced, the respiratory rate was rapid and the baby became markedly cyanotic. Wet rales were heard in the chest but the liver was not enlarged. Because of the rales and the possible coarctation of the aorta it was considered that the baby might have incipient heart failure. She was digitalized with digitoxin 25 mgms. per kg. and penicillin was started and maintained throughout the remainder of hospitalization. The baby's condition did not change with digitalization. The abdomen was constantly tense, there was dullness in the flanks and respirations became labored. Management was complicated by severe prolapse of the rectum. Abdominal paracentesis was performed and clear fluid drained for several days. The pulmonary edema cleared spontaneously following the paracentesis and the peripheral edema became less noticeable, eventually clearing completely by the 30th day after admission to the hospital. The baby was transfused repeatedly to restore the falling red blood count and on the 25th hospital day the temperature rose abruptly to 104°, remaining high. Rales could be heard in the lungs, Aureomycin was started and on the 31st hospital day the temperature suddenly rose to 105° and the baby expired. During the course of the baby's illness the total urinary output appeared to be about normal, although the accurate evaluation of the total excretion was not always possible.

#### LABORATORY FINDINGS

1-11-51. Urinalysis: yellow, clear, acid; S.G. qns; albumin +++; sugar negative; 10-15 WBC (HPF); 6-8 RBC (HPF); many epithelial cells; + bacteria.

RBC 4,300,000; WBC 15,300 Hb. 90 per cent 14.0 Gms.; 7 Eosins; 7 Stabs; 50 Segs; 34 Lymphs; 2 Monos.

Urea Nitrogen 36; CO<sub>2</sub> 53.1 Vol. per cent, 22.5 ml. eq.; Total Protein 4.0; Albumin 2.8; Globulin 1.2; Serum Chlorides 108 ml. eq., 631.8 mg. per cent.

1-16-51. Urea Nitrogen 34; Cholesterol 375; Total Protein 3.6; Albumin 2.0, Globulin 1.6.

1-18-51. Quantitative Albumin: 2.4 parts albumin/1000 (Pfeiffer Method).

1-19-51. Quantitative Albumin: 1 part to 1000 (Pfeiffer Method).

1-23-51. Urinalysis: yellow, clear, acid; Albumin ++++; Sugar negative; 6-8 WBC (HPF); 15-20 WBC (HPF); few epithelial cells; 6-8 Granular casts (LPF).

Blood Cholesterol: 338.



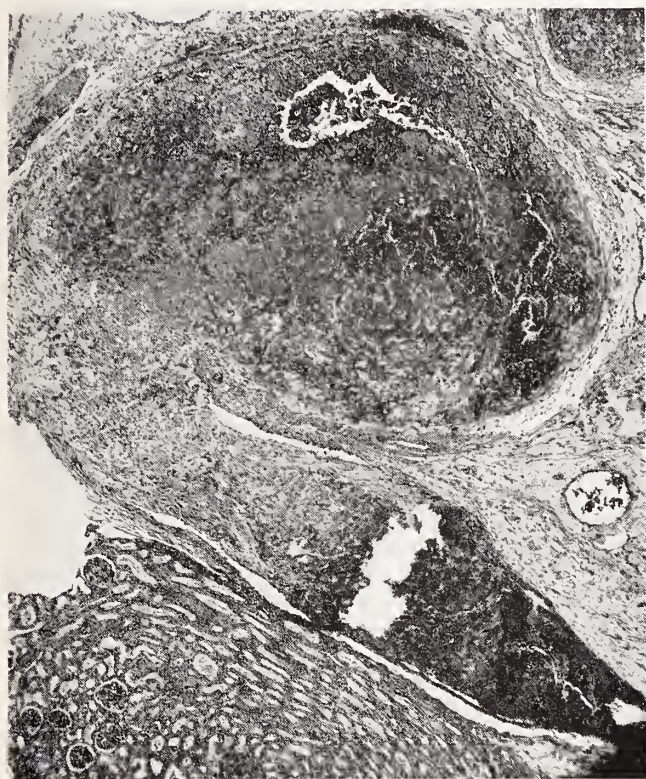


FIGURE 1

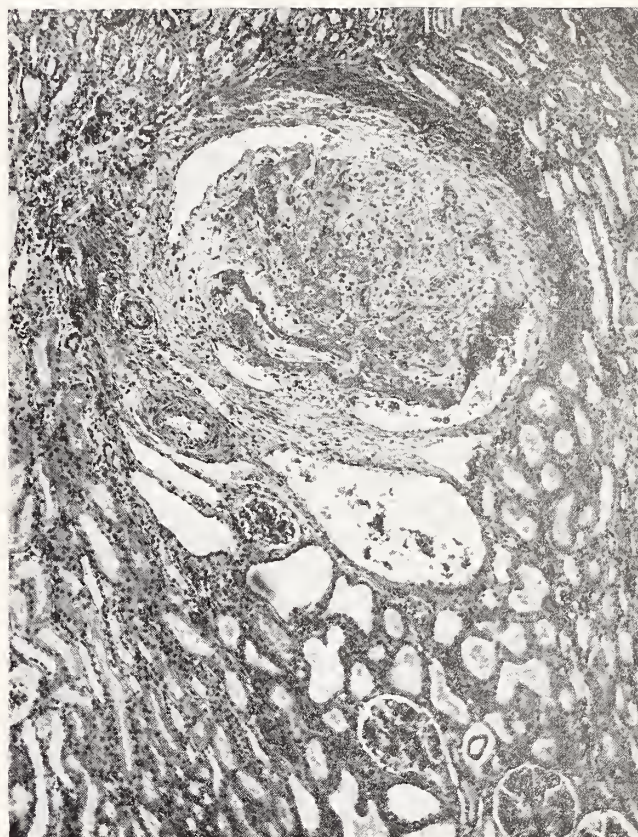


FIGURE 2

Sections through kidney showing thrombosed vessels  
(magnification 55  $\times$  and 110  $\times$  respectively)

1-25-51. Sedimentation Rate 46 mm. (Wintrobe).

1-26-51. Paracentesis Fluid: Protein 56 mg. per cent.

2-2-51. RBC 2,440,000; WBC 19,300; Hb. 56 per cent, 8.7 Gms.; 1 Eosin; 18 Stabs; 48 Segs; 24 Lymphs; 9 Monos; slight anisocytosis; slight hypochromia; slight polychromia.

2-5-51. Urinalysis: yellow, clear, acid; Alubumin +++++; Sugar negative; 0-4 WBC (HPF); 15-20 RBC (HPF); few epithelial cells; 10-15 granular casts (LPF).

2-6-51. Cholesterol 346; Phosphorus 3.9; Serum Chlorides 111 ml. eq.; 649.3 mg. per cent.

RBC 3,000,000; WBC 25,200; Hb. 63 per cent, 9.8 Gms.; 24 Stabs; 53 Segs; 15 Lymphs; 8 Monos; + Anisocytosis; slight poik., 1 Nucleated RBC seen.

2-7-51. Calcium 10.

2-9-51. RBC 3,510,000; WBC 30,800; Hb. 74 per cent, 11.6 Gms.; 1 Eosin; 22 Stabs; 54 Segs; 19 Lymphs; 4 Monos; + Toxic Granulation.

2-10-51. Urinalysis: yellow, cloudy, acid; S. G. qns. Albumin +++++; Sugar negative; 6-8 RBC (HPF) 12-14 Granular Casts (LPF).

2-13-51. Urinalysis: yellow, clear, acid; S. G. qns. Albumin +++++; Sugar negative; 8-10 WBC (HPF); 4-6 RBC (HPF) Ep. Cells few; Casts 6-8 granular Casts (LPF).

#### EKG AND X-RAY DATA

EKG: 1/11/51 Right Axis Deviation; Sinus Tachycardia. 1/23/51 Right Axis Deviation; Sinus Tachycardia. 1/26/51 Digitalis Effect. 2/5/51 Digitalis Effect.

X-ray: 1/11/51 ". . . aorta appears to be small in size . . ." ". . . no bony abnormalities of lower extremities . . ." ". . . fine mottling in both lung fields . . ." 1/13/51 I. V. Pyelogram—prompt secretion of dye by both kidneys. 1/16/51 I. V. Pyelogram—essentially normal. 2/10/51 Chest—clear lung fields.

#### AUTOPSY

*Body:* The body is that of a well developed, rather poorly nourished female infant, measuring 51 cms. in length and weighing 3000 Gm. The largest diameter of the head is 35 cms. and that of the abdomen 34 cms. The skin and mucous membranes are strikingly pale. Both fontanels are open. The scalp is covered with a good growth of brown hair, save for the temporal regions where the hair has been shaved. Large hematomas are noted over these regions. Rigor mortis is not present as yet, but there is postmortem lividity over the dependent portions of the body. The pupils are round, regular and equal, measuring each 6 mms. in diameter. The sclerae are free of jaundice. The cervical, axillary and inguinal lymph nodes are not felt to be enlarged. The trachea



appears to be in the midline. The thyroid gland cannot be palpated. There are no deformities of the bony thorax. The abdomen is quite protuberant. The genitalia are those of a female infant. There is considerable prolapse of the rectal mucosa. The extremities are symmetrically developed. Peripheral edema or clubbing of fingers and toes are not in evidence.

The incisions are made in the usual Y-shaped manner. There are at least 150 cc. of water-clear, colorless fluid within the peritoneal cavity which is lined by a smooth and glistening serosa. The abdominal viscera occupy their usual positions and relationships to one another.

When the chest plate is removed, the lungs do not collapse. There are just a few cubic centimeters of clear colorless fluid in either pleural cavity. The pericardial sac contains the usual amount of clear, straw-colored fluid. The pulmonary artery is opened in situ and found to be free of antemortem clot (blood culture taken).

**Heart:** The heart is somewhat larger than expected of an infant of this age and weighs 30 Gm. after removal of its postmortem contents. There are no malformations of the heart proper. However, the pulmonary artery, just above its valve, is wider than usual. The ductus arteriosus still has a narrow opening, and the aorta between the left subclavian artery and the ductus arteriosus is rather narrow, measuring about 5 to 6 mms. in width, in contrast to the ascending portion which is 10 mms. in width.

**Lungs:** The left lung weighs 40 Gm. and the right lung 50 Gm. There are numerous subserosal petechiae. The organs have a peculiarly mottled, brown-red appearance. There are numerous small foci of consolidation. Some semi-fluid, dark grey-brown material is noted within the bronchial lumina.

**Thymus:** The organ is practically replaced by a small amount of adipose tissue.

**Spleen:** The spleen weighs 10 Gm. It is invested by a smooth and transparent capsule. No pulp can be scraped off the cut surfaces. The Malpighian bodies are prominent.

**Stomach and duodenum:** No malformations.

**Pancreas:** This organ has the usual lobulated appearance and weighs about 4 Gm.

**Liver:** The liver weighs 200 Gm. Glisson's capsule is smooth and transparent. The parenchyma is pale brown in color with somewhat indistinct lobulations. There are no abnormalities of the bile ducts or blood vessels.

**Gallbladder:** Not remarkable.

**Adrenals:** These organs have the usual configuration. Together they weigh approximately 5 Gm.

**Kidneys:** These organs are remarkably large, the right kidney weighing 45 Gm. and left kidney 40 Gm. The fibrous capsules strip fairly easily, revealing remarkably pale, grey-brown surfaces with fetal lobulations. On section, the cortices are wide. The striations are fairly distinct. The pelves and calyces are not dilated and are lined by a smooth, grey-white mucosa. There are no abnormalities of the larger renal veins or arteries. The ureters follow their usual course into the urinary bladder.

**Pelvic organs:** No abnormalities.

**Intestines:** There are no appreciable lesions in the small or large gut.

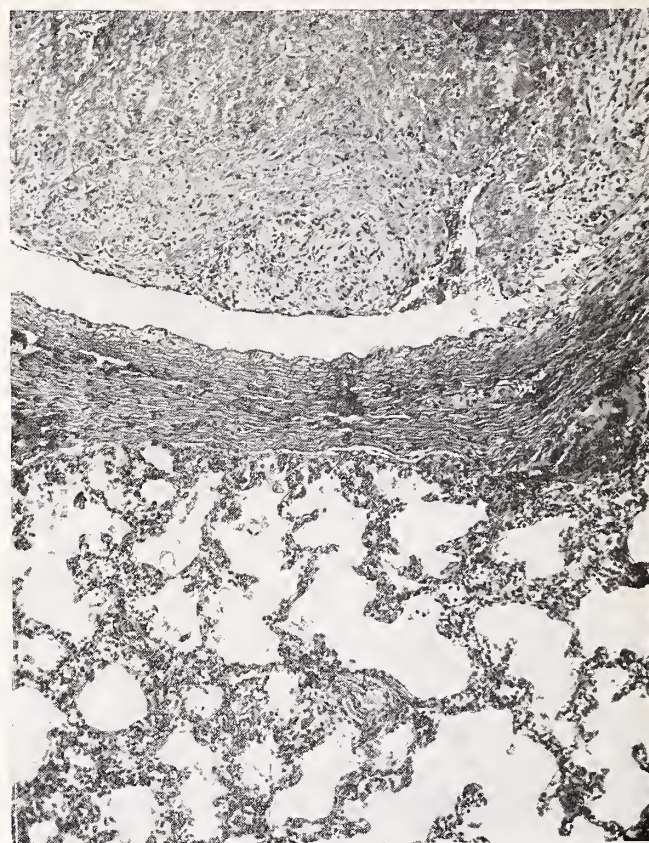


FIGURE 3

Section of lung showing detail of thrombosed vessel  
(magnification 110 X)

**Cranial contents:** There is no evidence of epi- or subdural hematoma. Save for considerable edema (interstitial), there are no pathological findings in the brain.

#### MICROSCOPIC

**Heart:** The visceral epicardium is represented by a thin fibrous connective tissue layer lined on its external surface by a single layer of mesothelial cells. The myocardium is compactly arranged. The nuclei are centrally located and the cross striations of the muscle fibres are distinct. There is no evidence of an inflammatory reaction or glycogen disease.

**Lungs:** Multiple sections of the lungs reveal numerous small branches of the pulmonary arteries as well as the veins—some partially and some completely occluded by thrombi in different stages of organization. There are scattered areas of peripheral atelectasis, areas of intra-alveolar hemorrhage and large foci of pneumonia, in some places of necrotizing character. A number of the small bronchi contain bluish or brownish staining, obviously aspirated material.

**Spleen, pancreas, liver:** Histological examination fails to reveal any appreciable pathological change. None of the vessels of the organs are the seat of thrombi.

**Adrenals:** The cortices are practically devoid of lipid.

**Kidneys:** Microscopically, both kidneys have a similar appearance. The parenchyma is intact, the glomeruli are well formed and the tubules are preserved and often filled with amorphous pink-staining material. Some of the smaller

intrarenal veins and numerous of the larger ones contain thrombi in various stages of organization.

It is noteworthy that neither in the lungs nor in the kidneys was there evidence of inflammation of the vessel walls.

#### DISCUSSION

The pathological physiology of this syndrome and the abnormal mechanism through which venous thrombosis occurs without coexisting endothelial damage is obscure.

It is known that in disease states and also associated with certain physiological conditions such as pregnancy, allergy, malignancy, there are alterations in the physical characteristics of the blood. Specifically there may be alterations in viscosity, changes in blood stream and alteration in electrical potential of the blood cells.

Normally red blood cells repel each other. However in the presence of shock or parenteral infection this quality appears to be diminished and cells agglutinate and the cohesion of these small masses to form larger conglomerates has been called sludging. This phenomena can be demonstrated in a drop of blood allowed to dry on a slide and in vivo has been observed in conjunctival vessels.

The kidney and lungs possess a double capillary network and in infants a particularly lowered arterial and capillary pressure which makes these organs a particularly favorable site for thrombus formation. Under conditions which would produce sludging—shock, dehydration, infection—cell masses which would resist passage through the truncated vessels of the kidneys and lungs are formed. The resistance of these aggregates further slows circulation through the kidneys and lungs resulting in endothelial hypoxia, seepage of fluid, further hemoconcentration, further sludging and continued thrombus formation. Retrograde thrombosis with sudden occlusion of a larger branch arteriole may

account for hemorrhagic infarction observed in many cases.

The case presented here is the only one thus far reported where a nephrotic-like syndrome was produced in an infant by intrarenal thrombosis. In this instance there was moderate birth shock and a seemingly insignificant skin infection. It is inviting to suppose that the amount of thrombosis was not enough to produce the acute clinical picture of renal failure but was enough to block many small arterioles and so interfere with renal function as to produce the chemical and physical characteristics of nephrosis.

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## ENDOCRINE THERAPY OF ARTERIOSCLEROSIS

### A Preliminary Report of 100 Cases

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#### SUMMARY

One hundred patients with arteriosclerosis were treated in accordance with a theory of physiologic rejuvenation using thyroid, androgen, estrogen, and multivitamins. Five case summaries are given. The average duration of treatment was three years, but a few patients were followed for as long as seven years. Three of the patients died before the treatment could be evaluated. Ninety-seven are alive and are pursuing their occupations in a manner approaching normal but avoiding overindulgence. The treatment described has afforded 85 a sense of well being and relief from angina pectoris, hypertension, and intermittent claudication. A lesser degree of relief was obtained in 12. Seven patients surviving cerebral arteriosclerotic episodes have been satisfactorily maintained.

A GENERALIZED rejuvenation of the physiology of patients with arteriosclerosis was undertaken. Such a concept of the treatment of arteriosclerosis is far removed from past practices of limiting the patient's activities and relying on sedatives, antispasmodics, surgical denervations, and custodial care, which generated the hopeless attitude that "one is as old as one's arteries."

While arteriosclerotic changes to some degree are almost universally present in middle aged and elderly persons, the young do not escape. The author has seen at necropsy well established atherosclerosis at age 5 and an extreme degree of coronary atherosclerosis with occlusion at age 33. The observations illustrate that age alone is not the determining factor in the disease.

Research on the etiology and pathogenesis of arteriosclerosis has been extensive.<sup>1-6</sup> A great deal

of data has accumulated to indicate that arteriosclerosis occurs as a result of altered metabolism of cholesterol and other lipids.<sup>1,4,7</sup> Estrogens alone and combined with androgens have been found experimentally to inhibit atherosclerosis,<sup>8-10</sup> and there is some indication from clinical findings that a beneficial effect may also be exerted in human beings with arteriosclerosis.<sup>11-13</sup>

The decision to pursue a hypothetical "rejuvenation" in arteriosclerotic patients was made several years ago. As a result of performing a series of roughly 3,500 necropsies, the impression was gained that many catabolic processes exist in these patients. The well nourished condition of most young human beings, who died from an acute illness or an accident, contrasted sharply with the fatty, degenerate liver, the fibrotic heart and kidney, and the generalized arteriosclerosis of middle aged and elderly persons. The medicinal agents planned for this treatment were to be from natural sources, nontoxic, and anabolic in function.

#### PRESENT STUDY

One hundred patients with arteriosclerosis were treated. The presenting symptom was angina pectoris, hypertension, or claudication. Some patients showed signs of cerebral involvement. Patients are grouped according to these signs and symptoms in the accompanying table which shows the medications used and the results obtained. The average age of the patients was 58 years, the youngest being 27 and the oldest 82.

Patients were instructed to eat a diet of easily digested foods, vegetables, cereals, and lean meats, and to avoid fatty, highly seasoned foods. Multiple vitamins, with an especially high intake of vitamin B complex and vitamins C and E, were prescribed. Thyroid extract was used in hypothyroidal patients, introducing it gradually and using doses of 1/10 to 1/20 grain at first. Lastly, estrogens and androgens

RESULTS OF ESTROGEN AND ANDROGEN ADMINISTRATION IN ARTERIOSCLEROTIC PATIENTS  
(CLASSIFIED AS TO PRESENTING SYMPTOM)

NO.	AGE	TREATMENT	DURATION OF OBSERVATION	RESULTS	
				GOOD	FAIR
ANGINA PECTORIS					
6	45-55	Oreton 25-50 mg.	1 year—4 3½-6½ years—2	6	
6	31-66	Oreton 10-50 mg. Progynon—B 0.3-1 mg.	3-6 years	5	1
1	49	Oreton 20 mg. Depo-Testosterone 20 mg. Progynon—B 0.2 mg.	6⅔ years	1	
1	57	Oreton 30 mg. Progynon—B 0.2 mg. Estiny 0.02 mg.	5 years	1	
12*	40-67	Micropellets Oreton—F 35-50 mg.	<1 year—2 1-5 years—10	10	1
2	59-71	Micropellets Oreton—F 30-35 mg. Progynon—B 0.2-0.5 mg.	2-4 years	2	
9	34-72	Micropellets Oreton—F 15-50 mg. Theelin or Estrone 0.1-2 mg.	<1 year—1 1-6 years—8	9	
1	68	Micropellets Oreton—F 25 mg. Estrogenic Substance 1 mg.	4 years	1	
2	62	Micropellets Oreton—F 35-50 mg. Dienestrol 0.5	7 months—1 2½ years—1	2	
1	46	Testosterone 45 mg. Theelin 2 mg.	3 years 2 months	1	
1	55	Testosterone 50 mg. Dienestrol 0.5 mg.	1 year 10 months	1	
1	54	Progynon—B 1 mg.	2 years 5 months	1	
—				—	—
43				40	2
HYPERTENSION					
6*	27-82	Oreton 40-55 mg.	<1 year—2 3-5½ years—4	5	
5	52-65	Oreton 30-50 mg. Progynon—B 0.2-0.8 mg.	2-5¼ years	4	1
1	64	Oreton 10 mg. Ovocylin 2 mg.	8 months	1	
3	59-69	Oreton 30-50 mg. Theelin or Estrone 1 mg.	1½-2½ years	3	
1	51	Oreton 35 mg. Depo-Testosterone 20 mg.	5¼ years	1	
6*	57-80	Micropellets Oreton—F 40-60 mg.	<1 year—2 2-6 years—4	3	2
15	42-79	Micropellets Oreton—F 30-50 mg. Theelin or Estrone 1-1.2 mg.	<1 year—5 1-6 years—10	14	1
3	53-72	Micropellets Oreton—F 40-50 mg. Dienestrol 0.5 mg.	<1 year—1 6 years—2	2	1
1	50	Testosterone 20 mg.	3 years		1
2	55-56	Testosterone 15 mg. Estrone 0.2-0.3 mg.	4½ years—1 6⅓ years—1		2
1	75	Testosterone 25 mg. Premarin 0.625 mg.	8 months	1	
1	66	Progynon—B 1 mg.	2¾ years	1	
1	60	Estrone 1 mg.	4 months	1	
1	55	Estrogenic substances Dienestrol	1 year 2 months	1	
—				—	—
47				37	8

PATIENTS RANGE		TREATMENT	DURATION OF OBSERVATION	RESULTS	
NO.	AGE			GOOD	FAIR
ARTERIOSCLEROSIS WITH CLAUDICATION					
1	68	Oreton 50 mg./wk. Progynon—B 0.4 mg.	3 years	1	
1	53	Oreton 35 mg./wk. Depo-Testosterone 10 mg. Progynon—B 0.3 mg.	4 years 10 months	1	
1	49	Micropellets Oreton—F 25 mg.	3 years	1	
—	3			3	
CEREBRAL ARTERIOSCLEROSIS					
1	63	Oreton 40 mg. Dienestrol 0.5 mg.	3¼ years		1
1	68	Oreton 35 mg. Progynon—B 1.6 mg./wk.	4 years 5 months—1	1	
1	56	Oreton 35 mg. Estrogenic substances 5000 I.U. Premarin 1.25 mg./3 per wk.	3⅔ years	1	
1	49	Micropellets Oreton—F 50 mg.	5¼ years	1	
3	55-72	Micropellets Oreton—F 25-50 mg. Theelin or Estrone 0.2-1 mg.	1 year—2 5¼ years—1	2	1
—	7			5	2
100†				85	12

\*One patient died before the results of treatment could be evaluated.

†Death in a total of 3 patients prior to evaluation of therapy.

alone or in well balanced ratios were administered in amounts suited to the needs of individual patients. As shown in the table, injectable forms of the hormones were used for the most part, the androgen usually as Micropellets Oreton—F\* (testosterone in aqueous suspension) or Oreton\* (testosterone propionate in oil), and the estrogen as Progynon—B\* (estradiol benzoate in oil) or estrone. Injections were made at intervals varying from one per week to one every second month.

The average length of observation was three years. No patient is included in whom treatment was continued for less than three months. The longest period of treatment was seven years.

In all, 85 patients showed marked improvement under this regimen. A result classified as "good" in the table usually meant that the presenting symptom—angina, hypertension, claudication—was relieved to a considerable extent. A sense of well being pervaded many patients. They could pursue their normal occupations provided overindulgence of every kind was avoided. The results of therapy can perhaps best be shown by the five case summaries that follow.

#### CASE SUMMARIES

##### CASE 1

A. B., 47 year old male. March 1947: Marked precordial distress radiating through the back and of three to four weeks' duration. Findings: Wt. 150 lbs. BP 115/75. Pulse 80. Heart regular, no murmurs. EKG: Elevated S-T segment in leads 2 and 3, depressed S-T segment in lead 4. Retinal arteries hardened and compressing veins. Diagnosis: Arteriosclerosis with coronary insufficiency and angina pectoris. No relief during treatment for seventeen months with multiple vitamins, theobromine, and phenobarbital. Treatment, June 1948 to date: Low salt, low fat diet. Oreton 50 mg. weekly for two months, every other week for two months, and then once per month. Thyroid 1/10 gr. daily started January 1951. Dose could not be increased because precordial distress returned when it was attempted. One Surbex tablet daily. November 1952: Oreton dose changed to 40 mg. and injected once per month along with 0.3 mg. Progynon—B. Result: Prompt relief of angina pectoris following use of hormones and vitamins. Patient able to resume his normal activities.

##### CASE 2

J. S., 53 year old male. June 1948: Abdominal cramps of two and a half years' duration; severe claudication initiated on walking two blocks; precordial pain on exertion; easily fatigued. Five years previously, jaundice occurred following a streptococcal tonsillitis treated with sulfonamides. Findings: BP 115/75. Pulse 80. Heart regular, no murmurs. Liver within normal limits, negative otherwise. Reflexes sluggish.

\*Manufactured by Schering Corporation, Bloomfield, N. J.



Summary of Lahey Clinic report: Moderate rubor and slow venous filling after lowering legs from elevated position. Fair collateral circulation despite high occlusion in both femoral arteries. Femoral pulses felt, but popliteal and pedal pulses absent. Minimal calcification of blood vessels of the legs visible on x-ray. Benzazoline test: Temperature of toes on right elevated  $2.2^{\circ}$ , toes on left scarcely any warmer. Diagnosis: Arteriosclerosis with intermittent claudication. Treatment: Vitamin A 25,000 units, vitamin D 1000 units, vitamin C 150 mg., vitamin B complex in relative amounts, and three Liafon capsules daily. Oreton 25 mg. per week for seven weeks. Despite relief of claudication, the patient sought treatment in a large clinic in another city. Priscoline administered there relieved pain for three weeks and then claudication recurred with increased severity. After three months, the patient requested resumption of hormone treatment. Treatment begun December 1948: Oreton 25 mg. per week for seven weeks, then 50 mg. weekly for one year. Marked relief of pain permitted the interval to be lengthened to three times monthly. In April 1952 the hormonal component of the medication was changed to Oreton 35 mg., Depo-Testosterone 10 mg., and Progynon—B 0.3 mg. per week. A larger dose of the long-acting testosterone proved too stimulating to the patient. Thyroid  $1/10$  gr. daily was used initially and the dose gradually increased to 2 gr. daily. The development of precordial distress at this dose forced a return to  $1/10$  gr. Subsequently  $7/20$  gr. daily was tolerated. Lyo—BC was given intravenously once a week for seven weeks. One Natopherol capsule 100 mg. per day was begun on April 4, 1949. In January 1952, the vitamin medication was changed to 100 mg. niacin three times daily, and vitamin B<sub>12</sub> 25 mcg., two Cebefortis tablets, one Abdec capsule, and one Natopherol capsule 100 mg., per day. This regimen is still in use. Result: All but occasional pain in the legs relieved for a period of more than four years following the use of hormone injections. The patient continues his normal business activities with no cardiac distress. During acute upper respiratory infections, blood pressure decreases and moderate leg discomfort is experienced.

## CASE 3

R. F., 68 year old male. January 1950: Severe claudication in both legs on walking. Previously treated with ulcer regimen, vitamins, and iron following reactivation of duodenal ulcer. Findings: BP 130/80. Pulse 68. Oscillometric pressure 4. Oscillometric pressure below knees: R  $3\frac{3}{4}$ , L 4; at ankle: R  $1\frac{1}{2}$ , L  $1\frac{1}{4}$ . Diagnosis: Arteriosclerosis with intermittent claudication. Treatment: One Vita-Kap capsule and one Surbex tablet, six Vi-Ferrin with Folic Acid capsules, and one Natopherol capsule 100 mg. daily. Thyroid  $1/10$  gr. daily. Oreton 50 mg. once weekly. May 1950: As claudication had ceased, Oreton was reduced to one injection of 50 mg. per week. The dosage of Natopherol was increased to three capsules daily and two Surbex with vitamin C tablets daily were begun. Thyroid was gradually increased to  $\frac{1}{4}$  and then  $\frac{1}{2}$  gr. on alternate days. April 1952: Oreton dose changed to 45 mg., and 0.6 mg. Progynon—B given concomitantly. Result: Claudication ceased after four months' treatment. After eight months the patient could pursue his normal activity mowing lawns without pain in

the legs. Oscillometric pressure, November 1952: Below knee: R 5, L  $4\frac{1}{2}$ ; at ankle: R 2, L 2. The patient has maintained a sense of well being.

## CASE 4

B. N., 68 year old female. October 1948: History of hypertension. Retinal hemorrhage and loss of sight in left eye five years previously. Findings: Wt. 169 lbs. BP 220/95. Pulse 80. Trace of albumin in urine. Heart regular, no murmur. Diagnosis: Hypertension. A low fat, low salt, and low caloric diet, and multiple vitamins were prescribed and 1.6 mg. Progynon—B injected. Next seen September 1949: BP 165/85. Pulse 84. Heart sounds regular, no murmur. Vertigo and precordial discomfort. Treatment: Progynon—B 1.6 mg. once per month. November 1949: Heart block, 2-5 per minute, arteriosclerotic in origin. December 1949: Cerebral occlusion, paralysis of right side of face, left arm, and left leg. Routine supportive care. Consciousness returned gradually and then control of the paralyzed areas of the body. Discharged from hospital in three weeks. Treatment: Low fat, low salt, low caloric diet. One Surbex tablet, one Zymacap, and 150 mg. Natopherol daily. Thyroid  $3/10$  gr. weekly, gradually increased to 1 gr. per week. Progynon—B 1.6 mg. per week initially, then one injection every two weeks, and finally one every three weeks. To avoid overstimulation by estrogen, Oreton 35 mg. was substituted for half of the estrogen in January 1952 and continued to date. This was deemed advisable even though the patient had not complained. Result: A slight but noticeable speech impediment is present when the patient becomes overtired but no other disability is present. Blood pressure has been maintained between 165/85 and 170/90. A sense of well being is maintained with Progynon—B and Oreton injections every three weeks but it has not been possible to lengthen the interval.

## CASE 5

E. W., 56 year old female. August 1949: Sudden severe headache four weeks previously. Findings: Pupils equal, no arcus senilis. Reflexes exaggerated throughout. Marked tremor when attempting to handle objects or move about. Heart regular, rate 96. BP 140/105. Hgb. 13.2 mg. per cent. RBC 4.12. BMR minus 1. Diagnosis: Generalized arteriosclerosis with cerebral episode, probable cerebral arterial occlusion without paralysis. Treatment: Fat-free diet. Two Surbex with vitamin C tablets, four Natopherol capsules 50 mg., and one vitamin A and D capsule daily. Oreton 35 mg. and 5000 units estrogenic substances per week. After two months the blood pressure dropped to 130/87. Thyroid  $1/10$  gr. daily and 1.25 mg. Premarin three times weekly begun. In the ensuing three years the thyroid dose was gradually increased to  $6/10$  gr. daily. In January 1950 the androgen injections were changed to Micropellets Oreton—F 40 mg. (1) one every two weeks for four months, (2) one per month for six months, and then (3) one every two months to date. The dose of estrogenic substances was continued at similar intervals. Result: The patient shows a slight degree of tremor. Otherwise there are no clinical signs of the arteriosclerotic condition that precipitated the cerebral episode.

## CONCLUSION

The reclamation of the patients treated to a comfortable and useful life justifies proposing hormonal-vitamin therapy for arteriosclerosis.

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## FAILURE OF EJACULATION PRODUCED BY DIBENZYLINE

## Preliminary Report

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## SUMMARY

Dibenzylamine, a potent adrenolytic agent of proven clinical effectiveness in some cases of hypertension and various peripheral vascular diseases, is being investigated for its value in adjunctive treatment of some psychiatric syndromes. Early in this investigation four patients independently reported absence of seminal emission in sexual intercourse. The growing literature

on this drug contains no reference to this particular pharmacologic action of Dibenzylamine. The four cases are summarized. The mechanism by which this sympatholytic effect takes place is described by reference to the physiology of ejaculation. Analogous data is cited from neurosurgery. Finally, some implications of this effect of the drug are mentioned.

*From the Veterans Administration Hospital*

*Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.*

*Dibenzylamine (N-phenoxisopropyl-N-benzyl-beta-chlorethylamine hydrochloride) is a product of Smith, Kline and French Laboratories which supplied the drug for use in this study*



**D**IBENZYLIN is an orally active adrenergic blocking agent which is chemically related to Dibenamine. It acts at the neuroeffector junction and is specifically sympatholytic, not affecting the parasympathetic system. It has been shown to exert an adrenergic blockade twice as effective as Dibenamine when given orally to animals. Clinical trials of Dibenzylin thus far have been concerned principally with the treatment of hypertension and peripheral vascular disease. Woodward et al<sup>1</sup> found it to be equally as effective as regional nerve block, and superior to tetraethylammonium, in increasing peripheral blood flow. Moser et al<sup>2</sup> described it in one study as "more effective than oral Priscoline and of great value in the treatment of Raynaud's disease and other vasospastic disorders, hyperhidrosis and causalgia." In another investigation Moser et al<sup>3</sup> concluded that their results with Dibenzylin in essential hypertension were comparable with those obtained with thoracolumbar sympathectomy.

The present authors have undertaken to carry out a comprehensive investigation of the value of Dibenzylin as an adjunct in the management of certain psychiatric syndromes. A rationale for such an application of the drug may be derived from the knowledge, established by the work of Diethelm et al<sup>4</sup> that anxiety is accompanied by an increase in demonstrable circulating adrenergic substances in the blood. It would seem a reasonable hypothesis that the chemical blockade of adrenergic effects would offer a way of minimizing some of the distressing components of anxiety in those psychiatric conditions where they play a significant part. Rockwell<sup>5</sup> reported on the use of Dibenamine in about fifty psychiatric patients "in whom anxiety, fear, panic, resentment, or anger, or the derivatives of these emotions were prominent or leading features in the psychopathology." Improvement in these patients "ranged from very mild to very marked."

Early in the present study, when only seven patients had been started on Dibenzylin, four of these patients reported within a brief period that they had experienced a failure of ejaculation (more specifically, a failure of seminal emission) in sexual intercourse. Three of the four patients were being treated on the ward, the fourth being seen as an outpatient. The latter was entirely unacquainted with the hospitalized patients; and it was determined with a high degree of certainty that the three hospitalized patients had not communicated with each

other about the phenomenon under discussion. When the first of these four patients described this effect it was tentatively regarded as an atypical form of neurotic inhibition of the sexual act. However, subsequent developments with the other patients mentioned made it quite apparent that failure of the seminal emission phase of ejaculation (hereinafter referred to as failure of ejaculation) represents a previously unobserved pharmacologic action of Dibenzylin.

In reviewing the literature on Dibenzylin particular attention was devoted to the side effects reported. An article by Haimovici<sup>6</sup> includes a representative summary of these side effects. These are enumerated here, with their relative frequency, according to that author, in parentheses: dryness of mouth and stuffiness of nose (common), drowsiness and fatigue (in a few), nausea and vomiting (rare), dizziness and palpitation (in several). Other studies have reported miosis, postural tachycardia and hypotension, and various degrees of asthenia.

#### REPORT OF CASES

##### CASE I

This is a 24 year old white married man whose presenting complaint was that of epigastric pain and vomiting most or all of every meal for the past several months. Onset of this symptom occurred during the last six months of 1951 when the patient had several hospitalizations for surgical treatment of a straddle injury and its sequelae. He was admitted to the NP service for observation because his Naval discharge carried the diagnosis of psychoneurosis. Medical work-up revealed a typical case of cardiospasm. He presented a passive-aggressive personality structure, with much evidence of poorly-masked generalized hostility. Accepted medical measures concurrently with psychotherapy failed to modify the symptoms. He was started on Dibenzylin on March 20, 1953, receiving 20 mg. b.i.d. through March 23, 1953, and 20 mg. t.i.d. from March 24, 1953 through April 8, 1953. From April 16, 1953 to April 20, 1953 the patient received placebos t.i.d. He had sexual intercourse on March 23, March 27, March 28 and April 11, 1953. On all these occasions the act was experienced by the patient as normal except for an absence of ejaculate. On the very first occasion this phenomenon was called to his attention by his wife who had failed to perceive the usual sensation imparted by the seminal fluid. On April 11, 1953 the patient used a condom, and found it to be completely dry after intercourse. There was no intercourse while the patient was on placebos, but the patient has reported that his ejaculations following April 11, 1953 have been entirely normal, as they had always been prior to these events. In addition to absence of ejaculation this patient experienced postural tachycardia and hypotension, dizziness and asthenia, nasal congestion and miosis. These effects were diminished or disappeared with use of placebos and discontinuation of Dibenzylin.



## CASE 2

This is a 31 year old white married man whose recent clinical history was characterized by about three years of progressively disabling anxiety attacks manifested principally by hypochondriacal complaints referring to all the major organ systems. His infantile-narcissistic character structure was revealed in the very strong dependency cravings reflected in all of his relationships. The characteristic defense mechanism was reaction formation, exemplified by aggression directed at those upon whom he was most dependent. In four hospital admissions in the preceding three years the patient had never become motivated for psychotherapy. At the time of this study he was being seen in outpatient interviews, while various measures were tried to effect symptomatic relief of the anxiety. Dibenzyline, 20 mg. daily, was started on March 22, 1953. In the absence of any effect on this dosage it was increased to 20 mg. b.i.d. on March 27, 1953. On this dosage the patient developed slight tachycardia, asthenia and drowsiness. On April 3, 1953 the patient had sexual intercourse which was normal in all respects except that there was absence of ejaculate as evidenced by a dry condom. He became rather anxious and discontinued the drug immediately. Intercourse with normal ejaculation occurred on April 5, 1953. Not being able to contact his physician who was temporarily away, and being reassured by the return of normal sexual function, the patient resumed the Dibenzyline on April 6, 1953 as he had been taking it prior to self discontinuation. Between April 6 and April 10, 1953 the patient had intercourse three times, experiencing failure of ejaculation each time, in an otherwise normal sexual act. In addition the patient reported the passage of "pure white urine" at the end of urination on 2 or 3 occasions. It should be noted that this patient's long standing neurotic illness had never before included disturbance of sexual functions.

## CASE 3

This is a 33 year old white married man with an eight to nine year history of recurring anxiety attacks characterized principally by sudden onset of dyspnea which usually occurs in the hypnagogic state just preceding sleep. The attacks have occurred at very irregular intervals and usually are followed by several minutes to several hours of apprehension. Careful periodic medical work-up has failed to reveal any organic chest disease. Psychodynamically, this patient's phobic symptoms were in reaction to expected retaliation for massive unconscious aggression toward authority. Toward his physician and other parent figures he was always very obsequious. Group and individual psychotherapy, as well as insulin subcoma therapy, received while still in the Army had been ineffective. The patient denied the obvious role of situational factors in his illness, and rejected psychotherapy. Dibenzyline was started in an effort to allay the anxiety symptoms. He received 20 mg. b.i.d. from March 25 to April 1, 1953; 20 mg. daily from April 2 to April 12, 1953; and 20 mg. t.i.d. from April 13 to April 15, 1953; placebos t.i.d. from April 16 to April 21, 1953. Intercourse occurred on April 4 and April 5, 1953, while the patient was on pass. On his return the patient spontaneously described failure of ejaculation in the otherwise normal sexual

acts. Past history revealed no evidence of sexual dysfunction. There was no intercourse while the patient was on the placebo. Subsequently, when all medication had been discontinued, intercourse was reported as entirely normal. Other side effects experienced by this patient were postural hypotension and tachycardia, slight dizziness, nasal congestion and transitory nausea. The latter effects disappeared while patient was receiving the placebo.

## CASE 4

This is a 28 year old married white man with an eight year history of recurrent anxiety attacks characterized by numerous phobias and a host of hypochondriacal complaints. A particularly bothersome symptom is a persistent hyperhidrosis. The clinical picture was that of a markedly passive-dependent individual greatly restricted in his functioning by overwhelming basic anxiety. Diagnostically he appeared to fit into the borderline category between severe neurosis and schizophrenia. In this case, unlike the foregoing, numerous conflicts in the sexual sphere had been reflected in occasional sexual impotence with his wife. On most occasions, however, the sexual act was normally performed. Dibenzyline was started in this case principally for its possible effect on the hyperhidrosis. He received 20 mg. b.i.d. from April 13 to April 21, 1953 and from May 3 to May 29, 1953. Perspiration was reduced to within normal limits while the patient was maintained on the drug. In spite of a continuing multitude of somatic complaints, none of these resembled the usual adrenolytic side effects of Dibenzyline. On return from a weekend pass he reported having had intercourse on May 16, 1953, and described this act as normal in all respects except that there was no emission. A concomitant, ill defined "pain in the groin" was also reported, but this is difficult to evaluate in the light of the patient's marked hypochondriasis.

## COMMENT

A significant clue to the mode of action of Dibenzyline in producing the effect of failure of ejaculation is the fact that the same phenomenon is occasionally observed as an untoward effect of bilateral thoracolumbar sympathectomy. The neurosurgical literature<sup>7,8</sup> records a number of differing opinions as to the relationship between extent of sympathetic resection and the occurrence of this untoward effect, as well as its duration. It seems generally agreed, however, that even with minimal procedures there is always some incidence of this phenomenon with the bilateral operation.

In the complex physiology of ejaculation the musculature of the epididymes, vasa deferentia, seminal vesicles, ejaculatory ducts, prostate, perineum and penis all must act in coordination. The peristalsis of the vasa deferentia, seminal vesicles, and ejaculatory ducts which discharges semen into the urethra, as well as the contraction of the internal vesical

sphincter which prevents reflux of the semen into the bladder, are induced by efferent impulses from the hypogastric plexuses which derive from the thoracolumbar (sympathetic) outflow. Dibenzylamine produces the failure of ejaculation by blocking these adrenergic impulses at the neuro-effector junction. Such semen as may reach the urethra might easily reflux through the relaxed internal sphincter of the bladder, later manifesting itself in the "pure white urine" reported by one of the patients described above. The rhythmic contractions of the ischiocavernosus and bulbocavernosus, as well as the other striated muscles of the penis, being under control of spinal nerves (perineal branch of the pudendal nerve), remain unaffected by the drug, thereby permitting that phase of the ejaculation to proceed normally.

It is a curious fact that this side effect of Dibenzylamine was apparently not observed previously. This is particularly striking in view of the fact that it has been administered to a sizeable number of male patients, many of them in the sexually active age range, and frequently in dosages far in excess of those used in this study. With the data at hand one can only speculate regarding the reticence of the patients and other factors that may be involved. It is expected that more light will be shed on this subject, as well as other topics of psychodynamic interest, in the main body of the investigation of this drug. However, it would appear indicated even on the basis of these preliminary observations, that there be some consideration of the possible emotional repercussions of failure of ejaculation in patients receiving Dibenzylamine.

Regarding the patient who experienced a failure of ejaculation three days following withdrawal of the drug, it should be remarked that most other investigators have reported persistence of the adrenergic effect from several hours to several days after discontinuing the drug, depending on dosage and duration of treatment. It is significant that the cardiospasm in one of our patients was entirely unaffected by Dibenzylamine. There is at least some empirical

basis for expecting relief in this condition from an adrenergic agent. While it may be considered that the dosage was inadequate, it should be noted that this patient was already in some distress due to side effects.

#### CONTROL DATA

Subsequent to the preparation of this manuscript a report appeared in which the investigators noted a "decrease in amount of seminal fluid" in 26 of 82 patients with vasospastic or occlusive vascular diseases who received Dibenzylamine. (Clinical experiences with sympathetic blocking agents in peripheral vascular disease. Moser, M. et al. *Ann. Int. Med.* 38:1245-1264, 1953.) The authors regard this report tentatively as control data, with non psychiatric patients for our present and continuing studies with psychiatric patients.

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## THE PHYSICIAN AND FEDERAL RETIREMENT PENSION PROGRAMS

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### SUMMARY

This discussion has concerned the principles and merits of retirement pension programs for professional and self-employed people with special consideration to the practicing physicians. Two concepts are involved, now already in operation for other vocational groups, the Social Security system with Old Age and Survivors insurance (OASI) and the deferred income program for retirement benefits. It is now possible to develop a program in which the physician may justly participate. The objective of the Social Security system is average coverage for the average wage earner. Alone it cannot offer to protect the individual and his family adequately. It is obviously more inadequate for the professional man and family. It can be used as partial and secondary coverage and integrated with other systems. Under these circumstances, it has more definite advantages. Its provisions need not be rejected since it is social insurance with the possibility of being extended to all income-earning citizens. Social Security may become a required and politically practical part of a professional pension program.<sup>9</sup>

The desirable and immediate objective of the profession should be the more effective and primary plan of income deferment for retirement pensions. Legislation in the form of the Reed-Keogh Bills will be introduced at the next Congress to provide a program for those in self-employed vocations and professions, including physicians, and should receive favorable consideration. There are new and complex problems in the organization of the machinery and

the fiscal and insurance policies involved in this legislation that may delay its enactment by Congress. Nevertheless, the Bills present a specific legislative program for unified action. Physicians should become aware of their provisions.

If they consider the program of sufficient importance and just, and the benefits for the individual self employed of proper value to themselves and to their dependents, they should individually and collectively express support for the passage of its essential features.

VARIOUS factors relating to income taxation and similar obstacles in accumulation of reserve for living expenses in the less productive and older years of life have made professional men cognizant of the hazards of the lack of such security and the need for appropriate measures, not only for themselves but for their dependents. Such measures are by no means sought unilaterally by the medical and other professions, they have already become an inherent and accepted policy in governmental positions, in academic life, and more recently in industrial management and labor unions.

The situation, as it affects professional men, of whom doctors are a numerical minority of the total of all such groups, has become of considerable importance in the past six years. Its recognition, perhaps, comes from facts, made obvious in these recent years, of high cost and overhead expenses, actual and potential monetary inflation, investment opportunities that are very limited unless managed by expert and time-consuming procedures, and especially high taxation. All of these conditions remain among the necessary and unchangeable problems for the future.

## EXCLUSION AND INCLUSION IN NATIONAL PROGRAMS

Though the financial status of the professional man has always seemed relatively secure, the social and economic environment in which he may now work as an individual has undergone profound changes. His economy as a self-employed individual may no longer be based entirely on his individual program of earned income, direct payment of taxes, savings when possible, investment undertaken for interest return and capital appreciation, and purchase of annuity benefits and insurance for his retirement and for financial protection of his family.

The social and economic changes of recent decades have established newer concepts and a different program largely conditioned by social objectives. The impact of these new concepts has affected many groups and a major proportion of the population, both of small and large income. It does not appear possible for any minority group to remain outside their fold without paying a penalty that can be greater than the restrictions incurred by inclusion. Non participation and participation, exclusion or inclusion in the national programs have advantages and disadvantages. The physician has come to a point where he must by desire or by force of circumstances take stock of his position.

## NATIONAL LEGISLATION

Two measures have been developed on the national level to provide the opportunity of meeting the necessary expenses of later non productive years. The first is the Social Security program initiated by Act of Congress in 1935. The second is the retirement or deferred income program with favorable tax status accorded to private pension plans and other employee-benefit plans in the 1942 Internal Revenue Code.

Both have their merits. Both place restrictions and demands upon participants. Both require analysis in order that the practicing physician may appreciate and decide on their relative values, either singly or together. Like the self-employed members of other professions, physicians have not heretofore been in a position to utilize one or the other.

## SOCIAL SECURITY AND THE PROFESSIONAL MAN

The Federal Social Security Law provides Old Age and Survivors insurance, termed OASI. Its economic and social objectives have been chiefly mass coverage for employed workers and financial assistance for the non-productive older years, after age

65. The coverage at first was restricted to employed wage earners. It is based on wage or earned income levels below \$3,600 annually. Due to recent changes it now provides a maximum payment of \$85 a month for a single individual or \$127.50 a month for a retired couple, with a substantial employment record of one of the married couple, and with no children under 18 years of age. The maximum monthly benefit, if children are still under 18 years of age is—\$168.50. The law was extended by amendment, which became operative on January 1, 1951, to cover certain groups of self employed, those who worked for themselves or for their own trade or business. The amendment did not include those who had self-employed earnings as farmers, lawyers, dentists, doctors, osteopaths, veterinarians, optometrists, licensed accountants, certified public accountants, authors, playwrights, funeral directors, professional engineers and other groups.

There are several advantages in the Social Security form of retirement and old age benefits. The benefits when obtained are not subject to income tax. When a program is initiated for a group, the older members of the group have a preferential advantage; their period of potential retirement being not far off, correspondingly their period of premium payments is short and their retirement benefits dollar-for-dollar relatively large. This advantage is to those now old and is obtained at the expense of the younger members of the group, who likewise are initiated into the system and must contribute annually at least to age 65. Future amendments may produce similar "windfalls" to those approaching retirement age. Once the group is included, it remains continuously under Social Security and all members must contribute, as early as income is earned. In time, therefore, all physicians would be affected in their younger years and would contribute regularly each year to age 65, and longer if employed. The benefits would not be obtained unless retirement occurred then; if retirement is delayed after age 65, the additional taxes may not seem to be actuarially justified. The survivors benefits may be advantageous in a limited way. There is a death benefit, as well as monthly survivors payments for a widow and children under 18 years of age.

Though certain pension advantages are present in OASI, the weakness which it (and other public retirement systems) presents has been the inequality of its distribution, the inadequacy of its benefits



which must be supplemented, and its failure to provide a more equitable arrangement in case the insured may change from covered to uncovered employment or retires prematurely. For the professional man it has certain handicaps for himself on retirement or for his family as survivors. Retirement benefits, not available before age 65, are also not available after 65 if the insured continues to earn income to the extent of \$75 per month or \$900 a year in the vocation covered by Social Security. For a physician to become a beneficiary is tantamount to retirement from active practice, if he is so engaged. After age 75 the law provides the benefits, even with continued earnings from the covered employment.

Social Security, being national and offering mass coverage, is designed only to provide a minimum standardized level of assistance or floor of protection. Its survivors, as well as its old age benefits, are small. The income without additional funds is inadequate for a widow and small child. Since the income for children stops at age 18, there is no income available during their college years. If and when the children are over 18, there is no income for the widow until age 65. But these individual survivor's benefits to the widow or children are eliminated or decreased if earned income by the wife or child in covered employment should exceed \$75 per month. The action of this work test poses a real problem for the family. It can make the Social Security benefits actually a "tantalizing mirage for a widow and her children" rather than an actual help.<sup>1</sup>

The inadequacy of the OASI benefits have been recognized. In this respect, the experience of the teaching profession which has some professional similarities to the medical profession is worth quoting. It or its representatives have been engaged for some years with the continuous evolution of an adequate insurance and annuity program. The 1950 Annual Report<sup>2</sup> of the Teachers Insurance and Annuity Association of America has the following comment:

"Last year a Joint Committee of the American Association of University Professors and the Association of American Colleges recommended with respect to faculty members and administrative officers that—

"As a normal goal the retirement system should

provide enough income to yield to a man who entered it at 30, and retired at the fixed retirement age of about 70, a retirement annuity of 50 per cent of his average salary over the last ten years of his service. If the fixed retirement age is under 70, the retirement annuity should, if anything, be a greater percentage of the terminal salary.'

"The maximum OASI primary retirement benefit provides 25 per cent of a \$4,000 salary; 20 per cent of a \$5,000 salary; 14 per cent of a \$7,500 salary and less than 11 per cent of a \$10,000 salary. The remainder must be provided by a supplementary plan."

Many colleges, universities, and publicly supported institutions have appreciated the inadequacy of the OASI program and have sought an integrating arrangement of the recent extension of the Social Security system with their primary retirement annuity programs. They have been encouraged in these efforts by the Teachers Insurance and Annuity Association to use the Social Security as a "second layer or protection." In 1950 this Association reported that 427 institutions with 52,524 staff members have coordinated the two.

It should be appreciated, first and foremost, that the OASI program alone is inadequate for professional men. Its utilization should only be considered "as secondary or coordinated coverage" after more effective and primary plans have been established. Though utilizing its benefits, many groups, recognizing the inadequacy of the National Social Security Law, have developed programs beyond its provisions. They include not only teachers, who have additional retirement programs as already discussed; government employees and officials on all levels from local to national; labor unions who have obtained independent or supplementary welfare and pension benefits; and corporation management personnel. To the members of these groups the opportunity for additional coverage was available in the traditional individual channels of saving from income, investments, insurance and annuity contracts. But, the impact of monetary inflation, advancing prices and high living expenses, higher standards of living, shorter working schedules, wage and price control, vastly increased national expenditures with or without war, and high income taxes placed too large a burden on the individual or his pensioning organization to afford such a traditional course.

## RETIREMENT PENSION AND EMPLOYEE BENEFIT PROGRAMS

Pension programs, by deferred salaries or profit-sharing or stock sharing, were already in effect to some extent with certain corporations. Pension programs by contributory salary percentages, have long been in effect in governmental positions. On the basis of equal contribution by the employee and by the governmental agency, the percentage contributed by the employee was withheld after income taxation was paid and increased by predetermined interest rates. The contribution by the government agency did not come under taxation until it was paid out as actual pension.

But the burden of any extended program could not be borne by the employer system or be of value to the individual employee without favorable considerations affecting both corporate and individual income taxation. For a business organization and its employees national legislation was required. It also required equitable adjustment of the claims for direct or fringe benefits of all employees from unskilled workers to management personnel. It was obtained in 1942 under more propitious circumstances than exist now. Amendments were then made by Section 165 (a) to the Federal Internal Revenue Code to allow companies and corporations to segregate funds for the purpose of providing employees with pensions or shares in profit-sharing trusts. Such monies would be deductible from gross receipts as business expense and be removed therefore from yearly taxation of the employer or business, provided the company plan has the approval of the Internal Revenue Bureau. In turn, since the employee (worker, foreman, office personnel, manager, president, or chairman of the company) does not receive the segregated income in the stated year, he pays no tax on such income, until he retires at stated age or cashes in on the profit-sharing accounts. The level of income tax on this deferred income is based not on its proportion to income when earned, but only when received on retirement. The income tax advantage is obvious.

The value of this legislation is attested by the steady increase in the number of pension plans in operation in business and industry or other incorporated activities. By the fall of 1951, the number of plans approved by the Bureau of Internal Revenue reached the total of 15,800 with 1,700 on file.

## FEDERAL LEGISLATION AND THE PROFESSIONAL MAN

The unavailability of this particular pension program to self-employed individuals obviously gave special treatment to selected groups. It exerted tax, economic, and security discrimination against professional men. Attempts to correct this inequality were initiated by individuals and by group organizations. It is not necessary to point out the growth of the cooperative effort to sponsor and to support measures that would receive favorable consideration by Congress.

Leadership in this movement has been provided by the American Bar Association. Through a special committee<sup>3</sup> it has taken measures to provide workable and legally effective bills. Along with other associations, the American Medical Association has joined actively through the action of its President, Board of Trustees and Bureaus in this cooperative action and has had continued representation for the Board of Trustees on the coordinating committee through Dr. Frank Dickinson, director of the Bureau of Medical Economics, and Mr. J. W. Holloway, Jr., director of the Bureau of Legal Medicine and Legislation of the Association. The Medical Society of the County of New York has also been represented through its Executive Secretary and Committee on Legislation.<sup>4</sup>

The difficulties of drawing and arranging appropriate bills have been many, but have been surmounted by the persistent work of the Coordinating Committee. Up until the past year, professional groups were not united on all specific programs. Cooperation has now reached the stage of effective action.

The Reed-Keogh Bills (HR4371 and 4374), "to permit the postponement of income tax with respect to a portion of earned net income paid to a restricted retirement fund" were introduced in Congress in 1952 but were held in committee. The technical features of the Bills and the form of retirement benefits obtained require complex actuarial analysis. For the medical profession the actuarial study has been given in the several detailed reports of Dr. Dickinson.<sup>5</sup> More favorable consideration of the Reed-Keogh retirement pension bills is now possible in Washington. The Bills will be reintroduced in Congress early in 1953 at the forthcoming session of the new Congress. During his recent campaign President-elect Eisenhower issued the following:



*Statement made by General Eisenhower on October 24, 1952 in regard to providing a voluntary pension system for self-employed taxpayers who cannot be governed under Section 165 (a) of the Federal Internal Revenue Code*

"The Government is rightly concerned with assisting its citizens to provide savings for their old age. The Social Security Act of 1935 embodied the doctrine that society through government should provide minimum benefits for the aged. We all favor this. In 1942 the Government made an important supplement to the Social Security Act by legislation which offered tax advantages to corporations and their employees in the establishment of pension funds (section 165 (a) of the Internal Revenue Code). I am thoroughly in accord with the principle of this legislation. Over 16,000 pension plans have been filed under this law providing more adequate security for the employees of corporations covered thereby. When this legislation was being considered, self-employed individuals were evidently forgotten. Yet, they get old and sick just as other people do. There are over 10 million workers who cannot take advantage of these tax relief provisions now offered to corporations and their employees. They include owners of small businesses, doctors, lawyers, architects, accountants, farmers, artists, singers, writers—independent people of every kind and description but who are not regularly employed by a corporation. I think something ought to be done to help these people to help themselves by allowing a reasonable tax deduction for money put aside by them for their own savings. This would encourage and assist them to provide their own funds for their old age and retirement. If I am elected, I will favor legislation along these lines."

Dwight D. Eisenhower

#### DISCUSSION

Though the Reed-Keogh Bills may have more favorable consideration in Congress, there are many problems to be solved before any retirement program for the self employed and professional man is established by law. To obtain an effective program will be even more difficult. It should be realized that the proposed Bills come under the jurisdiction of two committees—the Ways and Means Committee of the House of Representatives and the Senate Finance Committee. They give consideration to arguments, pro and con, on the principles of the

proposals and once the principles are accepted as sound, to the actual form of legislation and details of tax exemption. In addition to the scrutiny by members of the Committees at public hearings, the views of the U. S. Treasury Department will be introduced. It is an obligation of the Treasury to appraise the possible effect of proposed new legislation affecting the Internal Revenue Code and tax receipts. The basic principle of this proposed legislation presents an unique feature in the income tax structure.<sup>6</sup>

The Bills can, therefore, meet critical consideration, prolonged discussion, and delays even though there is the strong growing sentiment for the establishment of some type of retirement program sponsored by the Federal Government for professional groups. The legislative approval of some form of retirement system may not be too difficult. The larger problem of the machinery of organization, of fiscal procedures, and of administration of such a retirement system, may be major obstacles to the early evolution and actual operation of the program. If the problem concerned one profession only, it may not be too difficult. But it may well involve many professions and self employed to the extent of 10 million. An even greater issue can be the necessity to revise the existing programs and establish a new basic coordinated structure of a truly national pension program.<sup>7</sup>

The effect on tax revenue, the relation to existing Social Security and retirement legislation, the equitable adjustments of benefits within groups and among groups, the selection of fiscal machinery affecting banking and insurance methods are essential elements in the organization and administration. There are complex actuarial and insurance features to be worked out; these factors will require analysis and formulation by men of experience and judgment in insurance, banking, trust and legal fields, who have had heretofore the task of formulating such plans in education, government and industry.

The effort to obtain more favorable legislation for the professions may lead to coverage by the Social Security system as the initial and partial step. There is strong support from many, including members of Congress, to the concept that Social Security should be universal and retirement programs sponsored by Federal Legislation should be integrated with this system. At least, this integration has occurred with education, industrial, and corporate pen-

sion programs. Keeping out of the Social Security system when its benefits do not seem attractive may not be politically feasible or legislatively practical. Social Security may be advantageous to some compared to others. As a retirement program its benefits are not based on true actuarial principles, in that the return does not depend directly on the amount contributed. Its basis, however, is social benefits by mass coverage. Insurance-wise, it is to be viewed primarily as a "social" measure.<sup>8</sup>

#### EXPLANATORY NOTES

1. For more detailed discussion on these points see Bulletin of the Teachers Insurance and Annuity Association of America, April 1952 on "Social Security and Children's Benefits." Quotation as given.
2. Annual report for 1950 of the Teachers Insurance and Annuity Association of America, 522 Fifth Avenue, New York City.
3. The Special Committee was appointed March 25, 1950. The Chairman has been Mr. George Roberts of New York City. Mr. Roberts is also Chairman of the Coordinating Committee for the professions.
4. The New York Medical Society at its Stated Meeting, April 9, 1951, approved the resolution in favor of this program with instructions to its State Delegates to introduce a further resolution at the annual meeting of the Medical Society of the State of New York in May 1951; in turn to propose a resolution that the delegates from the New York State Medical Society to the American Medical Association present a similar resolution before the AMA House of Delegates at its annual meeting in June 1951. All such resolutions were approved.
5. These studies have been reported in the Journal of the American Medical Association from 1948 to 1952.
6. Correspondence with Senior Specialist, Tax Legislation, Library of Congress, Washington, D. C.
7. See recent report from the Joint Congressional Committee on the Economic Report. "Pensions in the United States." Prepared by National Planning Association, Washington, D. C. Comment in N. Y. Times, December 26, 1952.
8. At its Stated Meeting February 1951, the Medical Society of the County of New York disapproved a resolution in favor of inclusion of the medical profession in the Social Security system. At its Stated Meeting, March 1951 on reconsideration, the resolution was approved.
9. It is of interest that the governmental employees may not come under Social Security. In general, Federal employees cannot be covered if they have another retirement plan. State employees can only be covered if there is an agreement between the Federal Security Administrator and the State.

The Federal Internal Revenue Code 1942 defined more precisely the requirements for approval for corporate pension programs. The Act refers to an employer whether or not a corporation, association, partnership or individual.

In preparing this report, correspondence is gratefully acknowledged from Mr. George Roberts; Mr. Eugene Thore, General Counsel of the Life Insurance Association of America; Mr. W. K. Nichol, Assistant Actuary of Teachers Insurance and Annuity Association; Dr. Frank Dickinson, Director of the Bureau of Economics, American Medical Association; Mr. R. B. Gardner, vice-president, Chase Bank; Representative James E. Van Zandt, Member of Congress; Mr. Meyer Jacobstein, senior specialist, Library of Congress; and for a final review, Mr. Roger C. Hyatt.

The author is responsible for the contents of the article.



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

The JOURNAL extends its best wishes for a Happy New Year to all its many readers

### It's Part of Connecticut

When Connecticut Medical Service removed its offices to a new building on December 1, it was not simply transporting desks and things a few blocks down the street. The physical move was a practical symbol of a change, but there was much more to it than that. It meant the development of autonomous policy and complete rearrangement of operative procedures.

Unless it is well understood it will be difficult to appreciate what was involved in the physical transformation. For four years CMS had been the ward and small tenant of Connecticut Hospital Service and much of its housekeeping had been done for it. Then, suddenly, it found it must seek a new house, must increase its staff three fold and do all of its own business. This has all been done and done calmly and smoothly with no interruption of normal operations or delay in services to subscribers. As we watched it from day to day, it was satisfying to see the spirit and cooperation of all the employees, old, seasoned staff and newly hired ones who did not know each other. They worked alike and side by side; it was evidence of their loyalty and interest in an unusual job.

The new house is occupied now by a big new family, nearly four times as large as it was before, the complicated machines have begun their monotonous, superhuman routine and the material change is completed. Other things are yet to be realized, the months just ahead may bring questions that have

never been faced before but there is a will and experience now to face them.

The people of Connecticut have confidence in CMS and expect it to serve them; that is their only interest, they do not care where the office is. The medical profession believes in CMS, it is their child and they expressed their approval by spontaneous votes in the County Associations in October. The members of the Board of Directors, the Professional Policy Committee and the Executive Director (responsibility sleeps with the Captain) are interested and competent people who know what has to be done and will do it. Old disagreements will not be long remembered in the zeal of achievement and the satisfaction of service. It is truly "Part of Connecticut," vigorous and self reliant.

### Patient, Physician, Hospital

We are pleased to bring to our readers in this issue two pictures portraying hospital problems and written by experts in their fields. Mr. George S. Stevenson is well known to many of us in Connecticut and in his position of president of the Board of Directors of Grace-New Haven Community Hospital may well be termed an expert in the province of relationships between hospital boards of directors and medical and surgical staff members. He emphasizes the importance of a liaison committee operating between and for these two groups, where it has been sufficiently proven to be both practical and advantageous in many hospitals in which it has been in

existence sufficiently long enough for judgment to be passed.

The second article by Mr. Stewart of the Hartford Hospital should be read with care because it contains facts and figures which may surprise many physicians. It has been our contention always that doctors of medicine should concern themselves more widely with the administrative problems of their own hospital in order that they not only may be sympathetic and helpful to the administration but may be reliable informers of facts to their patients, the public. John Stewart has analyzed the trend in hospital costs over the past 12 years and it may be emphasized that the information commands serious thought, coming as it does from an expert in hospital administration.

### Comfort From the Opposition

*"A foolish consistency is the hobgoblin of little minds"*

Emerson

Even Communists have been known to realize the error of their ways and, after all, Communism is in theory a form of socialism. But we must not confuse the dictatorship of the Supreme Soviet with the theories of Marx (Karl not Groucho) and Engels nor with the creeping Fabian socialism which debauched Britain. Few of us read the *Journal of the American Medical Association* from cover to cover, but some must have noted Lord Woolton's recent remarks on socialized medicine as quoted by the *British Medical Journal*.\*

Lord Woolton had much to do with the framing of the National Health Service Acts although not responsible for their final form as adopted by the Labor Parliament and administered by Aneurin Bevan. Lord Woolton believed, as the medical profession has long believed, in supplying medical treatment for all who needed it regardless of their financial status. It has perhaps not been sufficiently emphasized that the form of socialized medicine proposed in the United States by the newdealers, compulsory insurance based on contribution by the employers and the employed, takes no heed of those unable to make such contributions. Presumably the medical profession will care for the poor and needy free, as they have for a long time. There has never been a lack of doctors willing to do this work.

Lord Woolton strikes at the root of all socialistic schemes when he wonders whether the "benefits" of the Welfare State might weaken the moral strength of the British people. He is quoted as saying that "more and more persons were turning to the State for things that they had previously provided for themselves through their own efforts and the more one is encouraged to depend on the paternal state by so much the more will his sense of personal responsibility be diminished and by so much the less will he tend to rely on his own efforts. Apparently, the more he gets for nothing the more he will expect to receive for nothing, and it may well be argued that the sick person should make some direct payment, however small, for the care he receives when he is ill."

Lord Woolton pointed out that, aside from the clergy, "the medical profession had a greater influence than any other over the citizens of the country" and that one of the responsibilities of the individual practitioner was to strengthen the moral fiber of the nation. He suggested that the more the State takes over the financial responsibility of the medical profession, the greater the risk of lessening the doctor's sense of responsibility and of "whittling away" the physician's ideals which have taken centuries to reach their present elevated plane. In a word, Lord Woolton emphasizes the importance of the spiritual, or as he calls it the "moral climate," in the welfare state as contrasted with the present purely materialistic attitude.

It is interesting that the spiritual aspect of the matter should have been stressed by a thoughtful person whose purpose at the outset of the socialistic program was doubtless to benefit the sick. He has found out by actual experience what others had already discovered before him, that "man does not live by bread alone," which is another way of saying that the government of human beings on a purely materialistic basis does not work. It is a sad commentary on our much vaunted civilization that intelligent human beings often fail to heed the lessons of the past, and it is indeed strange that in the United States, which has progressed for the most part because of the rugged individualism of its people, the mass of the citizens should have failed to realize this and should have fallen for the "creeping socialism" of the government in power. This statement does not imply that we have reached or will reach

\*Journ. Amer. Med. Assn., London Letter, 1952, 150, 237.



perfection under any particular political party for it is obvious that what we have failed to do is to learn how to get along with each other as individuals or groups. It is doubtless true that disagreement and controversy are elements in progress, but we are still a long way from the end of the road which is widespread mutual understanding, no doubt with some leeway for compromise on differences of opinion. As Robert Louis Stevenson put it in his Christmas sermon, "to have a few friends but these without capitulation." In a word we must learn to compose our disagreements both individually and in the mass on a friendly and reasonable basis.

G. B.

### Public Service

The award of a citation to John Gallivan, counselor from Hartford County and medical director of United Aircraft Corporation, for his contribution to the National Program for Employment of the Physically Handicapped serves to focus attention on this quietly working and extremely valuable means to end the national waste of human resources. President Eisenhower speaking before The President's Committee on Employment of the Physically Handicapped in Washington on September 23 said "There are many commissions and committees that carry with them the title of President's Committee or Commission. There is none that engages the interest of my heart, or of which I am prouder, than this one."

In recent years, particularly during World War II and since Korea, industry has become increasingly aware of the great untapped reservoir of manpower, the physically handicapped. Many of these pupils, while they have a physical limitation are really disabled only because of the thinking of their fellow citizens. Sometimes they have found it hard to get work because of lack of training or they themselves do not know just what they can do. Under press of demand for more workers thousands of these people have been trained to do specific jobs and the results are amazing. During the war it was discovered that out of some 25,000 jobs that had to be done handicapped persons could do a third of them.

As Sinclair Weeks, Secretary of Commerce, at the September meeting pointed out "There are obstacles of course. Many of these individuals need vocational training, and there are many business men who still have not been sold on the employment of

the physically handicapped . . . there is a continual educational job that has to be done. The cooperative meshing of efforts is an example of the American way of doing things . . . through the efforts of the State and local committees the public is getting a better understanding of what needs to be done for the handicapped, and what the handicapped man or woman can do for the community."

It is to all this that Dr. Gallivan has brought his fine knowledge and rich experience. The award is well merited and it was especially fitting that it be presented by Mr. John Connors who has served as the Chairman of the Connecticut Committee for many years. Mr. Connors knows the problem from every aspect and realizes the great results that can be accomplished.

### Meeting a Problem

Charles Shafer of the Pennsylvania Medical Examining Board in a guest editorial in the *Bulletin of the Federation of State Medical Boards of the United States* says, "All states are watching New York's effort to apply the old saying 'preach to please the sinners and fill the empty pews' to the staffing of state and municipal hospitals and institutions by throwing overboard all educational requirements for interns and residents therein." The Brydges Act amends the New York State Education Law to permit all hospitals to appoint interns without regard to educational qualifications and to allow all state and municipal institutions to appoint residents under the same conditions.

"Is it," Dr. Shafer asks, "a gradual return to the days before the Flexner report when the quality of medical practice fell so low that public opinion eventually forced the closing of second rate medical schools? Is it the start of a double standard for physicians in hospitals? Certainly, now is the time for the long look ahead by hospital trustees and administrators, medical educators, state legislators and all licensing bodies. In other words, we should all think twice before we allow temporary expediency to blind us to the public interest in having the highest possible standards for medical education and training."

Connecticut knows this problem well and until a few months ago harrassed administrators and intern committees, destitute of house staffs, were offering appointments to almost anyone in the great pool of

miscellaneous applicants whose educational antecedents were all but unknown. Occasionally there were pointed criticisms of Connecticut laws that were applied to keep some order out of what might have been the chaos Dr. Shafer fears in New York.

Finally, after conferences with hospital operators and physicians interested in intern recruitment, the Medical Examining Board sought an amendment to the Medical Practice Act. The Bill was passed by the General Assembly and became Public Law 189 in 1953. It allows the Board after review and approval of formal applications, to issue "Educational Permits" to physicians ineligible for license in this State to extend their education as interns or residents in hospitals here for periods of one year with possible renewal for a second year if their services are satisfactory. Thirty-four permits have been issued since the law became effective six months ago and two major objectives have been accomplished; first, the fine educational opportunities in Connecticut hospitals have become available to these physicians when hospitals are willing to accept them and second, many house staff posts have been filled that otherwise would be vacant.

Thus has Connecticut found a logical and reasonable answer to this pressing problem and control of it is properly delegated to the Medical Examining Board, a well informed public agency that is also responsible to the medical profession.

### Playground

When the Waterford estate of Mrs. Mary Stillman Harkness was willed to the State for health purposes it was almost a white elephant. No one knew quite what to do with it until Governor Lodge suggested that it be utilized as a day camp for the physically handicapped.

The camp is under the jurisdiction of the State Park and Forest Commission but is largely administered by a health advisory committee which was established after consultation with the State Medical Society. Harry L. F. Locke, pediatrician, West Hartford; Louis Spekter, chief, Division of Crippled Children, State Department of Health; Neil A. Dayton, superintendent, Mansfield Training School and Hospital; and Ward J. McFarland, orthopedist, New London, are members of the committee. Dr. Locke serves as its chairman.

In a report recently filed with the Governor, Dr. Locke stated, "Connecticut may well be proud of its

leadership in providing such a recreational mecca for its physically handicapped population. We predict a rapid expansion in the use of Harkness as knowledge of its many benefits becomes more widespread." The 1953 season brought an attendance of 3,736 physically handicapped persons plus 1,413 escorts and supervisors. In 1952, when the camp was opened, the attendance approximated 2,000. It was recommended in the report that the 1954 season for the camp extend from early June through most of September and with additional cabins with sleeping accommodations designed for patients who live some distance from Waterford.

This is a unique project and is evidence of Connecticut's interest in its handicapped citizens.

### Resolution in Memory of Dr. Samuel C. Harvey

The Connecticut Division of the American Cancer Society hereby officially records, with deep sympathy and grateful recognition of service rendered, its sorrow over the passing of the late Dr. Samuel C. Harvey.

OUTSTANDING WORKER in the origin and growth of the Connecticut Division, as a member of the Board of Trustees from 1947 to 1952; as an Honorary Trustee from 1952 to the time of his death; as chairman, in 1948, of the first committee to plan and establish the Annual Connecticut Conference for Physicians; as Advisor to the New Haven Branch of the Connecticut Division; and as recipient, in 1950, of the American Cancer Society Connecticut Division Award and Medal for Distinguished Service in Cancer Control.

WELL KNOWN EDUCATOR, and first Professor of Oncology, whose teaching work at the Yale University School of Medicine earned for him a place of enviable reputation in American medicine and contributed valuably to the development of surgical skills on the part of those who studied under him.

PROMINENT SURGEON for many years.

CIVIC LEADER, whose broad humanitarian interests were spread over a wide front of activities benefiting the state and community.

BE IT RESOLVED that a copy of this official memorial tribute be sent to the family of Dr. Harvey with the heartfelt sympathy of the officers and members of the Division.

October 15, 1953



## THE PRESIDENT'S PAGE

### MALPRACTICE CLAIMS

He is most free from danger who even when safe is on his guard

**M**ALPRACTICE claims have increased tenfold in recent years which may be an important factor in the rising malpractice rates and the withdrawal of many insurance companies from this field.

No doctor regardless of the special field of medicine in which he is engaged is immune from these claims, and prevention is the best, if not the only, defense.

All authorities agree that unwise comments or destructive criticism by a physician of the treatment given a patient by another physician accounts for 50 to 80 per cent of all malpractice suits. We must avoid malicious and unethical remarks about the work of others.

Another reason for such claims is the rendering of insufficient care such as failure to adequately x-ray injured parts, failure to make a complete diagnosis, failure to utilize an established treatment, as the administration of tetanus antitoxin, failure to safeguard a patient from falling, failure to properly perform an operation, failure to obtain permission for surgery, failure to examine adequately, failure to be diligent, failure to inform the patient or his family of an unfavorable change in the patient's condition, failure to keep abreast of medical knowledge.

There are many things that every physician can do or avoid doing in order to prevent malpractice claims. Some of these measures are (1) keep good medical records; (2) avoid any guarantees or over optimistic prognoses; (3) advise patients of any intended absence from practice and recommend, or make available, a qualified substitute; (4) secure written consent to operation and for an autopsy; (5) insist on consultations particularly if the patient is not doing well or seems dissatisfied; (6) use adequate x-ray examinations especially in cases of suspected or possible fractures; (7) practice within one's field of professional qualifications and keep abreast of the times; (8) avoid experimentation; (9) avoid any admission of failure or fault, and never make it known that you carry professional liability insurance; (10) avoid examination of a female patient unless a third person is present as the charge of undue familiarity is extremely serious and destructive; (11) prepare a patient carefully for the probable results of treatment; (12) discuss fees with the patient in advance as a misunderstanding in this matter can contribute an avoidable element of risk.

The importance of carefully kept medical records and protective consultations should be stressed. The records should show clearly what was done, if the patient discontinues treatment too early, fails to follow directions, or refuses to have an x-ray taken. Consultations should be held on every case, even the simplest, whenever the cause and progress are unfavorable or the patient or family appear dissatisfied. This not only divides the responsibility but will help to prevent hostile criticism, charges of unskillfulness, or misdiagnosis.

Doctors must learn what they can do to protect themselves against malpractice claims. This important problem has been seriously neglected by the medical profession and needs special emphasis. Like a wise man, learn to profit by the errors of others.

George H. Gildersleeve, M.D.

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## Semi-Annual Meeting of the House of Delegates

The 1953 Semi-Annual Meeting of the House of Delegates was called to order by the Speaker of the House, Dr. Gibson, at 4:30 P. M., on Thursday, December 10, at the New Haven Medical Association, 364 Whitney Avenue, New Haven, Connecticut.

### REPORT OF THE PRESIDENT

Dr. Gildersleeve presented the mid-year report of the President and outlined the activities of the Society since the Annual Meeting in April including the awards of the first medical school scholarships.

### SCHOLARSHIP AWARDS

One year ago this House appropriated the sum of \$2,000 from the unallotted surplus funds of the Society for the purpose of awarding three scholarships of \$500 each to residents of the State of Connecticut who were in their fourth or final year in an approved medical school in the United States or Canada and an additional \$500 to be allotted for nursing school scholarships to residents of Connecticut who were in nurses training in schools in this State.

The selection of a recipient of the award of the nursing school scholarship was delegated to a committee of the State Nurses Association that awards the nursing scholarship provided by the State of Connecticut. Awards were made by the Society to three young women enrolled in schools of nursing in Connecticut. They were:

Clara Whitman of Bristol in training at Grace-New Haven Community Hospital School of Nursing, New Haven.

Anne Pistarelli of Naugatuck in training at St. Mary's Hospital School of Nursing, Waterbury.

Ruth Meadnis of New London in training at

Hartford Hospital School of Nursing, Hartford.

The responsibility for the selection of recipients for the medical school scholarships was given to an anonymous scholarship committee appointed by the President several months ago and that committee reports that forty-eight applications were received. This is approximately 50 per cent of the Connecticut students who will graduate from medical school in June of 1954, six were young women. The committee reports that arriving at a decision as to which three of this group should receive scholarships was most difficult. The procedure followed was that each of the three members of the committee reviewed all of the applications independently and made a list of those whom in his mind topped the list in desirability. The committee then met and compared these lists. Finally there was general agreement as to the selection.

The recipients are:

Richard Michael Demko, a native of Manchester, now a resident of Rockville. Mr. Demko attended Manchester High School, University of New Hampshire and received his A.B. "with distinction" from the University of Connecticut in 1949. He is now in his senior year at New York University-Bellevue College of Medicine. He is married and has a three months old daughter. His father is a mill worker. He has provided with the aid of the G.I. benefits 100 per cent of the cost of his medical education. He expects to enter general practice in the State of Connecticut.

Michael Lawrence Fezza, born in New Haven and is now a resident of that city. He attended New Haven High School, received his B.A. from Yale College in 1949. He is now a student at New York Medical College and has maintained a scholastic average of 84 per cent throughout his course. He is a member of the Student Senate. He is married and expects a child in the spring. His father is a factory



worker. Mr. Fezza has contributed about one-third of the cost of his medical education and expects to return to Connecticut to enter general practice.

Francis Hobson, born in Plainville, now a resident of Plainville. He attended Plainville High School, received his B.S. from J. C. Smith University and is now in his fourth year at Meharry Medical College, Nashville, Tennessee. He is not married. His father is deceased and the expenses of his medical education have been paid through his own efforts and casual employment by his widowed mother. He expects to specialize in urology and return to Connecticut.

These students have been informed of the awards and checks will be sent to them at Christmas time.

#### REPORT OF THE SECRETARY

##### MEMBERSHIP AND DUES PAYMENT STATISTICS

COUNTY	MEMBERSHIP				MEMBER-SHIP DECEMBER 10, 1953
	MEMBERSHIP JANUARY 1, 1953	NEW MEMBERS ELECTED	RESIGNED DROPPED, DECEASED	ETC.	
Fairfield	717	43	13	8	739
Hartford	865	35	12	16	872
Litchfield	120	5	2	1	122
Middlesex	97	2	2	4	93
New Haven	778	50	8	16	804
New London	155	10	0	5	160
Tolland	16	0	0	1	15
Windham	60	4	2	0	62
	2,808	149	39	51	2,867

##### DUES STATISTICS

COUNTY	STATE SOCIETY DUES UNPAID	AMERICAN MEDICAL ASSOCIATION DUES UNPAID
Fairfield .....	31	13
Hartford .....	19	9
Litchfield .....	4	2
Middlesex .....	3	2
New Haven .....	13	16
New London .....	7	2
Tolland .....	0	0
Windham .....	1	1
	78	45

Total billed.....2,597

Total exempt ..... 231

Total billed .....2,329\*

Total exempt ..... 237

\*Members who did not pay 1952  
AMA dues were dropped

The unusual number of deaths during 1953 was noted, 39 in comparison to 25 in 1952. It was also

stated that included in this number were many members who had been prominent in the Society's affairs, particularly two past presidents, Samuel C. Harvey and Joseph H. Howard. The secretary recommended that a Resolution Committee be appointed to prepare an appropriate statement on the death of these two late officers of the Society. The report was adopted and the Speaker appointed, Chairman, Edward J. Whelan, Charles T. Flynn, Sr., and Franklin S. DuBois to the Resolutions Committee.

#### REPORT OF THE TREASURER

The treasurer read a report for the year 1953 and presented the budget for 1954 recommending that dues for next year continue at \$25. After brief discussion including questions as to why the appropriation to the Woman's Auxiliary was omitted for 1954, the budget was passed and 1954 dues approved as recommended. It was moved and voted that the appropriation to the Woman's Auxiliary be referred to the Council and if, in its opinion, the Auxiliary needed to have the appropriation that had been given for the last two years continued, the Council use its discretion in making such an appropriation from the surplus funds of the Society.

#### NOMINATING COMMITTEE

Thomas J. Danaher reporting for the nominating committee proposed that the executive secretary of the Society, Creighton Barker, be a delegate to the House of Delegates of the American Medical Association to fill the unexpired term of the late Joseph H. Howard, until December 31, 1954. Nomination for this office commencing January 1, 1955 for two years will be presented to the House of Delegates at the Annual Meeting, April 27, 1954, as required by the By-laws. It was moved and voted that a single ballot be cast in favor of Dr. Barker's election.

#### RESOLUTION ON EUTHANASIA

The Speaker recognized Christopher E. Dwyer, president of the New Haven County Medical Association, who sought permission to present a resolution from the New Haven County Medical Association in condemnation of Euthanasia. The House voted to accept the resolution for consideration and the Speaker referred it immediately to a previously appointed Reference Committee consisting of William H. Curley, Jr., Ralph T. Ogden and Brae Rafferty.

REPORT OF PROFESSIONAL POLICY COMMITTEE OF  
CONNECTICUT MEDICAL SERVICE

Thomas J. Danaher, chairman, reported for the Professional Policy Committee of Connecticut Medical Service and proposed that the House of Delegates give its approval to contemplated changes in the CMS contract that had been recommended by the Professional Policy Committee and the CMS Board of Directors. These changes would include:

(a) Raising the service income limit to \$5,000 for family, \$4,000 for man and wife and \$3,000 for single subscriber.

(b) The schedule of indemnities would be increased to a \$300 limit up to a maximum of \$1,800 in any one calendar year.

(c) The in-hospital medical care benefit would be increased from \$3 to \$4 per diem and from 21 days to 120 days during a calendar year.

(d) X-ray benefits would be provided in the physician's office according to the 1952 Workmen's Compensation Schedule up to a maximum of \$50 in a calendar year for each member with \$10 deductible for each radiological service.

(e) An increase in monthly premium rates from \$2.85 to \$3.60 for a member and enrolled family, \$1.90 to \$2.40 for subscribing member and spouse and \$.90 to \$1.20 for a subscribing member.

After long debate a motion to table (and to take up for consideration at the Annual Meeting in April), was passed by vote of 35 to 30. Following this action, it was moved and voted that all members of the Society be informed on this subject and an opportunity be given for discussion "at the county level." A subsequent motion to remove the matter from the table for immediate consideration was lost.

AMA HOUSE OF DELEGATES

Stanley B. Weld, delegate, presented a detailed report of the transactions of the Interim Meeting of the House of Delegates of the AMA in St. Louis, December 1-5.

CITATION FOR JOHN N. GALLIVAN

John N. Gallivan, councilor from Hartford County and medical director of United Aircraft Corporation, East Hartford, was presented a Citation for Distinguished Service by the President's Committee on National Employment of the Physically Handicapped by John L. Connors, chairman of the Connecticut Committee. Dr. Gallivan replied

appropriately. Mr. Arthur V. Geary, secretary of the Connecticut Committee also made brief remarks.

REPORT OF THE REFERENCE COMMITTEE ON  
EUTHANASIA RESOLUTION

The Reference Committee on the resolution condemning Euthanasia reported recommending the passage of the resolution and it was passed unanimously. This is the Resolution:

WHEREAS: Many members of this Society have received a questionnaire from the "Voluntary Euthanasia Society of Connecticut" making inquiries as to whether the recipients would condone or practice euthanasia in patients suffering with incurable diseases, and

WHEREAS: the Hippocratic Oath, to which all physicians subscribe, includes this pledge:

"I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death"—and

WHEREAS: the Board of Governors of the New Haven County Medical Association has unanimously voted that it is unalterably opposed to and condemns the practice of euthanasia and cannot condone it in any manner or form whatsoever, proposes therefore—

THAT: this House of Delegates at its Semi-Annual Meeting on December 10, 1953 affirms the pledges made by physicians under the Hippocratic Oath, and condemns the practice of euthanasia.

MESSAGE TO DR. MURDOCK

The secretary was directed to address a letter of sympathy and best wishes for a speedy recovery to Thomas P. Murdock, who is hospitalized at this time.

Meeting adjourned at 7:00 P. M.

STUDENT MEMBERS ELECTED—Continued

Richard J. Brown, New Haven  
Tufts College Medical School—Class of 1957  
Pre-Med: Yale  
Parent: Joseph J. Brown

Nathan Cohen, Hartford  
University of Rochester School of Medicine—  
Class of 1957  
Pre-Med: Cornell  
Parent: Charles Cohen



Pasquale J. Costa, New Haven  
Yale School of Medicine—Class of 1955  
Pre-Med: Boston University  
Parent: Nickolas Costa

Neil G. Diorio, South Norwalk  
University of Vermont Medical School—Class  
of 1957  
Pre-Med: St. Michael's  
Parent: Gennaro Diorio

Eric A. Frederickson, Norwalk  
University of Rochester School of Medicine—  
Class of 1957  
Pre-Med: Wesleyan University  
Parent: Eric L. Frederickson

Ralph A. Goddard, East Hartford  
Boston University School of Medicine—  
Class of 1957  
Pre-Med: Emory University  
Parent: Harvey B. Goddard, M.D. (deceased)

Anna Kris, Stamford  
Harvard Medical College—Class of 1957  
Pre-Med: Radcliffe College  
Parent: Ernst W. Kris

Gerald Labriola, Naugatuck  
Jefferson Medical College—Class of 1957  
Pre-Med: Yale University  
Parent: Patsy Labriola

John J. Lawrence, Stamford  
Howard University College of Medicine—  
Class of 1957  
Pre-Med: Manhattan College  
Parent: Harry Lawrence (deceased)

Richard N. Lucas, Middletown  
New York University—Class of 1957  
Pre-Med: Wesleyan University  
Parent: G. Albert Hill, M.D.

Joseph A. Moriarty, Manchester  
St. Louis University School of Medicine—  
Class of 1957  
Pre-Med: University of Connecticut  
Parent: Joseph J. Moriarty

Alan M. Nahum, Hartford  
Tufts College Medical School—Class of 1957  
Pre-Med: Yale University  
Parent: Milton Nahum

Lewis M. Neporent, Hartford  
Syracuse Medical College—Class of 1957  
Pre-Med: Washington University  
Parent: William Neporent

Abner L. Notkins, East Haven  
New York University—Class of 1957  
Pre-Med: Yale University  
Parent: Louis A. Notkins, M.D.

Robert D. Osborn, South Norwalk  
Yale School of Medicine—Class of 1957  
Pre-Med: Colgate University  
Parent: (deceased)

John V. Schiavone, Waterbury  
Georgetown Medical School—Class of 1957  
Pre-Med: Holy Cross  
Parent: Albert D. Schiavone

Bernard Snow, New Haven  
Tufts College Medical School—Class of 1957  
Pre-Med: Yale University  
Parent: Harry Snow

Norman A. Zlotsky, Hartford  
Tufts College Medical School—Class of 1957  
Pre-Med: Yale University  
Parent: Julius Zlotsky

### Meetings Held During December

- December 2—Committee on Neonatal Mortality  
Committee on First Aid in Home
- December 3—Scholarship Committee  
Civil Defense  
Woman's Auxiliary
- December 7—Cancer Coordinating Committee
- December 9—Subcommittee on Toxemia in Preg-  
nancy  
CMS Board of Directors
- December 10—House of Delegates  
Committee on Public Health
- December 15—Conference Committee with State  
Dental Association
- December 17—Committee on School Health
- December 18—Conference on Polio Vaccine
- December 30—Committee on Alternate Councilors

The Council will meet at the office of the  
Society on January 14.

## Special Article

### DO YOUR PATIENTS REALLY LIKE YOU?

ERNEST DICHTER, PH.D.

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The Author. *President, Institute for Research in Mass Motivations, Inc.*

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NOTHING is a safer topic for conversation than doctors and the medical profession. A group of people may have had violent disagreements, but when the discussion is shifted to doctors, most of the people present will probably agree. Unfortunately, in most cases, they will agree on negative facts about the medical profession. Even those people whom you would not consider capable of unfairness and subjective attitudes, will join in gleefully to report incidents from their own experience where doctors were wrong, over charged, drove around in Cadillacs after only one year in practice, split fees, and a long list of comparable horror tales.

From a public relations viewpoint, and to the researcher in human motivations, a big question mark poses itself. How come? Why, from among all the various possible scapegoats in modern human society, are doctors picked, and what can be done about it? How can we make patients like their doctors more? Several years ago I was asked by the Alameda Contra Costa County Medical Association, to investigate this doctor-patient relationship, to find out what was wrong with it and what could be done about it. Since then I have conducted a number of additional studies. One major one for C.P.S., the California Physicians Service, on specific problems in connection with health insurance, and a number of experimental studies to determine in what ways the doctor-patient relationship can be improved.

First, was the diagnosis. What was wrong? Summarizing our findings, what had happened was that while the world was changing and changing very

rapidly; while the patient in this world was changing at least at the same pace; while all the medical equipment, medical knowledge and drugs were developing at an ever increasing rate; the HUMAN aspect in the doctor-patient relationship had fallen behind. A psychological lag had taken place. We discovered that most doctors choose their profession for idealistic reasons. Though a good income is usually expected, and this factor does enter into the picture, the idea of helping humanity and doing something worthwhile, uncommercial, and out of the doldrums of everyday life, of devoting oneself to helping others, is very strongly accented. Something vital and very important happens to the young doctor during the course of his major studies and particularly during his internship. The young doctor discovers the harsh realities of life. These realities very quickly clash with his initial, highly exaggerated idealism.

The patient, as well as the doctor, becomes aware of this conflict. The doctor often exaggerates his idealism to over compensate for the recognition that in many ways, he really has to behave like a businessman. The patient on the other hand, is asked and expected to pay respect comparable to the kind of reverence that one pays to a saint, and then a few days later he receives a bill—again a conflict is the result. A further difficulty stems from the fact that while the modern patient is catered to by most other business and professionals, and even large corporations, the medical profession as a whole has failed to acknowledge that this patient has been growing up, is insistent on his right to be treated as an equal, and spoken to in clear understandable language. The modern patient doesn't want to be called a "layman," he doesn't want to have complicated Latin phrases thrown at him, which he feels he would understand



quite well if they were translated. Every time he is in contact with a doctor, he feels he is confronted by a clique. He is the outsider, the child, the ignominious.

The modern citizen, and thus the modern patient, has been invited to become a participant, rather than a passive recipient in more and more fields. There are profit-sharing plans; do it or make it yourself is the latest and most modern development in many fields of industry. The home workshop, the ready mixes, fix it yourself plans; new approaches in labor-management relationships, where labor becomes a participant in management decisions, all point to an entirely new direction. His relationship with the doctor seems to be in complete contrast to this. Instead of being permitted or invited to be a participant, he is told to simply hold still and follow instructions.

A further important trend which has been observed in our modern culture, is the desire for emotional security. Before the last election, it was predicted that in times of prosperity, the party in power stays in power. This prediction was wrong. Why? Because a psychological factor was overlooked—that people in general want more than just financial security. They need emotional security as well. Applied to the medical field, it means that the technological assurance, the mastery of x-ray machines and antibiotics, while highly desirable, is not enough. We often overlook the fact that progress does not take place in a straight ascending line, that a much more correct picture is the one of a spiral development. While it seems logical that progress has such a steady development, that greater and greater efficiency and scientific expertness on the part of the doctor was all that was demanded, our studies show conclusively that not only in this field, but in many other fields, people really want to be assured of the return of this spiral development. They want to come back to the kind of relationship on an emotional level that they used to have with their doctor. But in a more developed and scientifically more dependent form.

Even in the industrial field, our studies showed that such companies as General Mills, General Motors, Ford, etc., have to take care of the emotional problem. A company like General Mills had to invent a personality like Betty Crocker in order to establish a relationship between themselves and the consumer—a relationship of a psychological and

emotional form. In other words, it is not enough for them to produce an excellent flour and to have perfect production facilities, what is even more important and what finally determines the success of their commercial undertaking, is the existence or non existence of this emotional tie.

Comparably, therefore, the modern doctor too can have the most perfect laboratory equipment in his office, be qualified through medical knowledge in the most unquestionable fashion, and yet be completely deficient as far as the basic requirements of his profession are concerned. These requirements of having an emotional relationship with his patient used to be the standard equipment of any good family doctor. A modern patient feels that he has been cheated, that he has x-ray machines instead of human relationships. He clamors, therefore, and with a great feeling of justification, for the old family doctor to be brought back, minus the horse and buggy, of course, and equipped with the x-ray machine and all the other scientific advances.

In our surveys we discovered that the doctor is proud of his rugged individualism. Yet this individualism is as outdated as the frontiersman who totes his gun would be today. The modern patient is no longer allowed to be this kind of rugged individualist. Recently it was pointed out that there are hardly any employers left. Most of us are employees of a large corporation or business enterprise. In the final analysis, even the president of General Motors is an employee, with all the psychology that goes with it. What right has the doctor to consider himself beyond the law, above the restrictions that are imposed on almost every other citizen in our society?

Therefore, the modern patient demands that his doctor interest himself in community affairs as much as he himself is expected to participate. He demands that the modern doctor accept his responsibility as far as medical care is concerned. This is another source of conflict, another source of jealousy and frustration.

In this short time I cannot go into all the details of the various studies concerning the doctor-patient relationship which we conducted. The diagnosis can be summarized in the following way:

It is not the high medical fee; it is not even the threat of catastrophic illness nor the imperfection of medical science; nor any other surface reason given by people when asked directly, which can serve as the explanation for this lack of love on the

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1. Hild, A. M.: Schweiz. med. Wchnschr.  
71:557, 1941.

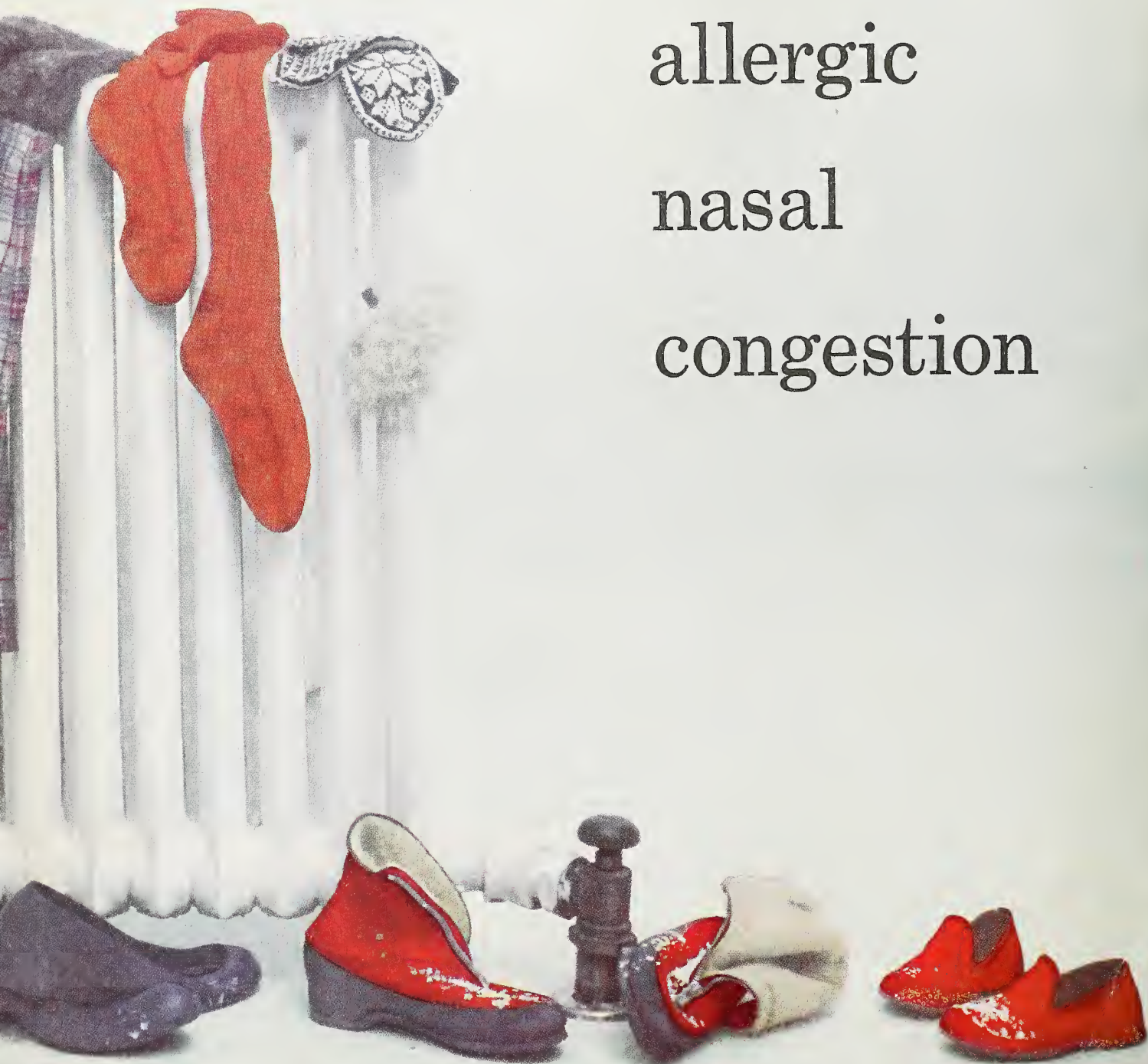
2. New and Nonofficial Remedies,  
J. B. Lippincott Co., Philadelphia, 1953, p.

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1. Dill, J. L.: *Postgrad. Med.* 4:413, 1948.

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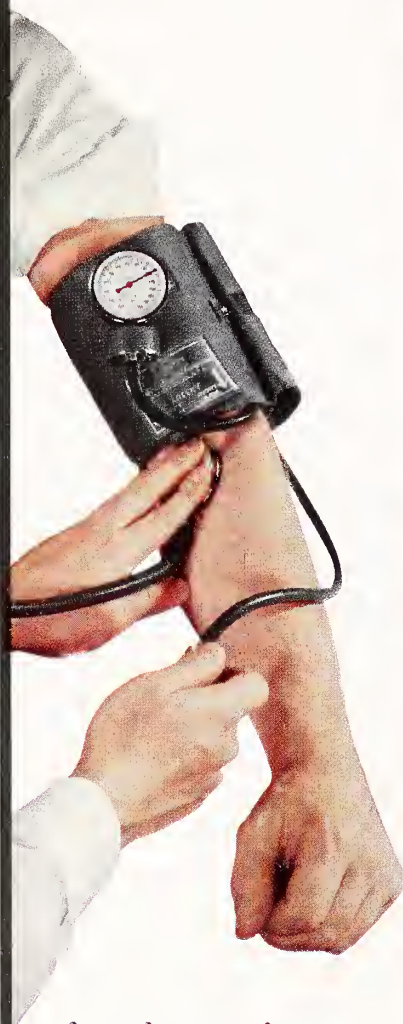
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1. Hafkenschiel, J. H., and Lindauer, M. A.: *Circulation* 7: 52, 1953.
2. Schroeder, H. A.: *Circulation* 5: 28, 1952.
3. Riven, S. S., Pocock, D. G., Kory, R. C., Roehm, D. C., Anderson R. S., and Meneely, G. R.: *Am. J. Med.* 14: 160, 1953.
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part of the modern patient for his doctor. We have to dig deeper, as we did in our psychoanalytic approach to the problem, in order to find out what some of the real faults in this relationship are. As the examples we have presented demonstrate, most of them point to a feeling of frustration. The modern patient wants to be loved by his doctor. The modern doctor would like to love his patient, have a personal relationship with him and spend as much time as possible with him. Both, in a sense, are caught in this dilemma. The modern doctor is not permitted to be the idealist he really feels he ought to be. The modern patient feels he is not being treated the way he really feels he ought to be treated. He states, as one of our respondents did, "All he did was make me well."

You might say, "This is the typical, ungrateful attitude of a patient."

As a psychologist, I would say, "No, this is the outcry of a person who feels let down, neglected, and robbed of what he thinks his doctor should have given him—love, interest and affection."

What is the answer? What can be done about it? How can we make the patient love his doctor? What therapy, as far as public relations are concerned, can we prescribe? It is my conviction that the answer does not lie in political maneuvers, in lobbying, or any other form of high pressure advertising approach. We must give each individual physician a manual, a prescription, or better yet, the tools to develop insight into his own relationship with his patients and urge him to put these things into practice bit by bit. Only by such a systematic approach, starting with each individual doctor, can we hope to achieve a generally improved relationship between the doctor and his patient. Here is a list of concrete recommendations:

#### 1. DO YOU HAVE THE RIGHT KIND OF PATIENTS?

Make a list of all the patients whom you have treated in the last year or so. Next to their names jot down your own personal feelings about them. How many of them do you really like, how many of them do you detest, how many of them are you indifferent to? If there is an undue number of patients that you would rather not have further contact with, your public relations with your patients is not too good.

#### 2. HOW MANY OF YOUR PATIENTS WOULD YOU PERMIT TO CALL YOU BY YOUR FIRST NAME? HOW MANY OF YOUR PATIENTS DO YOU CALL BY THEIR FIRST NAME?

If the ratio, the difference, is a very large one, again I would say that here you have another symptom of poor public relations between yourself and your patients. One of the important aspects of our study revealed that authoritarian relationships between the physician and the modern patient are on their way out. While many doctors claimed that the patients wanted them to feel authoritarian, experiments that we conducted not only in the medical field, but also in labor management fields, proved that it is quite often the opposite that is really true. For example, we found that the doctor who took his patients into his confidence, who admitted that he didn't know all the answers, who dealt with them on an equal, non authoritarian basis, reaped great benefits from this kind of relationship. The patient, rather than losing confidence in his doctor, had increased confidence in his humanitarian and ethical principles and trusted him even more than if he simply pretended to be the authority.

#### 3. HOW MANY OF YOUR PATIENTS LOSE CONTACT WITH YOU AFTER YOU HAVE CURED THEM?

We found that the desire for continuity is a very important one in the modern patient. He does not want to have contact with you only when he is sick. He wants to have the feeling that you watch over his health and his family's health all year long. We found that patients remembered the days when their family doctor carried their whole destiny and recorded all their family events in his little black book. This knowledge of continuous care and interest on the part of their doctor is a very important one for the improvement of the doctor-patient relationship.

Have you ever sent your patients cards? Do you ever inquire, after you have prescribed a treatment, whether it actually worked or not? Do you consider the relationship has ended when the patient has paid his bill? Do you ever send a thank you note after you received your payment, inquiring at the same time about the health of your patient? We conducted a number of experiments which showed that the patient was puzzled at first, then tremendously



pleased by this demonstration of a new era, a new philosophy, on the part of his doctor. Contrary to the fears which some doctors expressed, that this would be interpreted by the patient as solicitation and commercialism, the modern patient interpreted this to mean that the doctor too has finally acknowledged the fact that it is his job to please the customer. The principle of continuity is practiced by insurance companies, gas stations, dentists, lawyers. The patient feels that the doctor should not think himself above this, should not feel himself exempt.

#### 4. HOW MUCH PARTICIPATION DO YOU GRANT YOUR PATIENTS?

We found that when you write out your diagnosis, when you fill out those mysterious sheets in your office, the patient wonders what it is that you are putting down. We found dramatic and miraculous effects, when the doctor tore off the top sheet, handed it to the patient with proper explanations and informed him what all this mysterious writing meant. In this way, the doctor demonstrated that he considered the patient his partner, not a "layman," who had to be dealt with like a child.

#### 5. HOW MUCH MEDICAL INFORMATION, SPECIFIC OR GENERAL IN NATURE, DO YOU DISSEMINATE IN YOUR OWN COMMUNITY?

Many doctors complained that the patient read articles in popular magazines indiscriminately, and then pestered the physician with questions, suggesting therapy himself, and so forth.

While it is perfectly correct that much of this information may lead to misinformation, a large part of the blame really falls back on the medical profession. The modern patient wants to have the Bible translated into English. He wants to know what is going on. He feels that anything that concerns his own body is primarily his own prerogative. If he cannot get information from his doctor, his medical association, or the medical profession within his community legitimately, he will try to get it somewhere else. No complaints will ever be effective until the medical profession understands that this is a justified need of a psychological nature for the modern patient, which must be satisfied one way or another.

Why shouldn't medical associations disseminate this information themselves, with the help of local newspapers, radio stations, television stations and so forth. Why would it not be possible to send out

monthly or quarterly bulletins signed by the county medical association, with the names of the doctors who work in the county listed. This would give patients the feeling that all they need to know about diseases, epidemics, adjustments to seasonal changes and so forth, is made available to them by the medical association.

#### 6. HAVE YOU LOOKED AT YOUR WAITING ROOM LATELY?

To a certain extent, the waiting room is the display room, the show window of the medical practitioner. Why call it "waiting room" to begin with? Nobody likes to wait. In our studies, we found that the patient has a great desire to learn more about his doctor. He wants to establish an emotional relationship with him. What are you doing to help it? For example, there is nothing wrong with having a family album in the waiting room, which would show the patients what you did during your last vacation; introduce him to your family; give him insight and information about yourself as a living, human being and not just a technician in the medical field. What are you doing to make your patients more comfortable while they wait? How old are your magazines? Are there any cigarettes or candy offered? In what other ways can you help make the waiting period more pleasant? Have you considered slide projectors?

#### 7. DO YOU EXPLAIN YOUR APPARATUS TO YOUR PATIENTS?

More and more, modern factories have introduced open house sessions which permit the families of their employees, factory workers, etc., to visit all parts of the enterprise and familiarize themselves with various machines. Couldn't something similar be done as far as the medical profession is concerned? We found that many of the modern patients were quite eager and curious in not just an idle fashion, to learn more about the various apparatus and instruments their physicians use. It is quite conceivable that the nurse, an assistant, or the doctor himself should show the patient his facilities and explain his apparatus and various instruments to him.

#### 8. AS A PHYSICIAN, HOW DO YOU PARTICIPATE IN YOUR COMMUNITY?

It is possible to cooperate on a community level with schools, for example. Certain school periods could be used to introduce various medical practices and medical apparatus to the children and familiarize them with these. This would diminish their fears and teach them to consider the doctor a professional

man with special knowledge, and not one who is a saint, nor a medicine man with magic, mysterious, dangerous apparatus at his disposal.

#### 9. WHAT IS THE ROLE OF YOUR MEDICAL ASSOCIATION?

Most patients consider the medical association of their county a mysterious building where secret sessions take place. Patients think of their doctors meeting as members of a clique to protect themselves against the intruders. Why not make these buildings open to the public, arrange exhibits in them, invite the community to come and see; to sit in on some sessions. Perhaps some day medical associations will have the courage to invite so-called "laymen" to become members of the community and representatives of the patients. They might even be granted a vote in some decisions.

#### 10. ARE YOUR NURSE AND/OR WIFE HELPING YOU?

The doctor's wife and his nurse have many functions which can be used to facilitate the practice of the doctor. Often a patient feels frustrated because there's not enough time for him to discuss all the details with the doctor. Couldn't the nurse be trained to have sessions of this sort, in the way that an investigator, a researcher who works with the scientist, would do? She could more readily afford to spend half an hour with the patient, prepare all the information for the doctor so he is aware of the problems when he deals with the patient.

#### 11. WHAT IS YOUR REACTION TO STANDARDIZATION OF FEES?

In my opinion, the fee problem, though dependent to a large extent on emotional frustrations, deserves a specific approach of its own. It is not so much the absolute figure of the fee, the cost itself, that the patient objects to, as the feeling that he has developed that "biological blackmail" is exerted on him. He feels he is charged for the value of a limb to him, the value of his life to him, instead of on what he considers a fair basis—the doctor's knowledge, time, effort and responsibility.

It is my belief that at one point open and above board standardization of fees will have to be introduced. It has been done in some counties with excellent results, as far as the public relations value is concerned. We found that the patient does not

object so much to what he is being charged, as to not knowing in advance how much he will be charged. We found that a president of a large corporation, earning \$150,000 a year feels just as strongly about being "blackmailed," as he called it, as the factory employee who earns \$75 a week. What they resent is being reminded of their helplessness and having the doctor take advantage of his power. It is only natural, therefore, from a psychological viewpoint, that they are waiting for the day when they can take this power away from him.

I've tried to list a number of concrete suggestions. Again, I must say these are only a few examples.

What we must realize is that the problem of socialized medicine versus free medicine, like any other problem in our modern life, cannot be approached simply from a political or economic viewpoint. In most of the discussions in this sphere, very little acknowledgment was made of this apparently overlooked, and apparently insignificant factor—The Human Mind. When your son starts to grow up, you will not get very far by disciplining him, refusing to let him ask questions and denying him the right to make his own decisions. You will lose out in the end because you are working against his growth and maturity. A wise approach is to acknowledge the fact that your son is becoming a man.

The patient, too, is growing up. He insists on his right to ask questions. He wants to be loved, not in a condescending, paternalistic fashion, but as an equal partner in the fight against the difficulties of modern life.

I think that the answer to improved public relations will not lie in insistence on rugged individualism and absolute freedom, nor in federalization and socialization of medical care. The answer will lie in a new democratic form of cooperation where the individual gives up some of his prerogatives, accepts the responsibility of the health of the community, recognizes the rights of his patients and learns to cooperate with them.

The answer to how to make your patients like you more lies in recognizing the fact that this world is a changing one, that the patients are changing, and that you too must learn to change with them.



## Dr. John N. Gallivan Cited for Outstanding Service by Presidents' Committee on Employment of the Physically Handicapped



Dr. George H. Gildersleeve, President of the Society, congratulates Dr. John N. Gallivan, Chief Medical Supervisor of the United Aircraft Corporation, East Hartford, who is holding a Citation for Outstanding Service awarded to him by the President's Committee on Employment of the Physically Handicapped for his leadership in creating employment for more than 12,000 handicapped workers.

The presentation was made by John L. Connors, right, of Hartford, Chairman of the Governor's Connecticut Committee for Employment of the Physically Handicapped, during the semi-annual meeting of the Society's House of Delegates, December 10 in New Haven. Arthur V. Geary, Hartford, Secretary of the Governor's Committee, left, addressed the meeting following the presentation and expressed appreciation for the contributions of the Society and its members in establishing a leading place for Connecticut in the national program for the physically handicapped.



## Presentation Address

JOHN L. CONNORS, Chairman

Governor's Connecticut Committee for Employment of the Physically Handicapped

I have the privilege today of representing the President's Committee on the Employment of the Physically Handicapped as well as the Governor's Connecticut Committee for the Employment of the Physically Handicapped.

The occasion is the presentation to Dr. John N. Gallivan of a "Citation for Outstanding Service" in the national and state program for employment for handicapped workers.

Dr. Gallivan was recommended to the President's Committee for this high honor by joint action of the Governor's Connecticut Committee and the Connecticut State Medical Society.

The reasons for presenting the name of Dr. Gallivan as Connecticut's nominee for this national recognition were presented to the President's Committee in some detail. In view of the strong evidence presented covering his outstanding achievements in advancing the employment of handicapped workers it is logical and natural that the President's Committee voted to award this "Citation for Outstanding Service" to him.

It would be impossible in a short talk to furnish all the details of the outstanding contribution made by Dr. Gallivan to this cause. I will attempt, therefore, only a brief outline.

Dr. Gallivan's record of service in behalf of the physically handicapped began, of course, with his medical education. He received both his Bachelor of Arts and Doctor of Medicine degrees from Tufts College, Medford, Massachusetts, completed his internship at St. Francis Hospital, Hartford, and entered into private practice of medicine in East Hartford in 1936. In 1937 he became assistant chief medical supervisor of United Aircraft Corporation, being promoted to chief medical supervisor in 1938. For a number of years after his employment by United Aircraft he continued his private practice until the tremendous expansion of United Aircraft in World War II made this impossible. Incidentally he has continued his medical education through post graduate courses in occupational medicine, industrial hygiene and safety engineering at Yale University.

His responsibilities at United Aircraft increased

with the growth of this concern so that now as chief medical supervisor he also supervises the safety engineering and health insurance programs as well as the division of medicine and hygiene.

Under his leadership the United Aircraft Corporation developed a program of modern personnel practices, safety engineering and health insurance which has made this concern a recognized leader not only in the full utilization of all general advances in industrial medicine but also in the development of new policies, new ideas, new systems and new procedures.

Some of the major features in Dr. Gallivan's program are the full utilization of the skills and abilities of new employees including, of course, a complete program for the selective placement of handicapped workers in suitable jobs—jobs in which their particular physical limitations offer no handicap to efficient productive job performance. (2) Periodic examinations of employees by the medical staff. (3) Close coordination of the work of the medical division, safety division and the foremen to insure the continued good health and safety of the individual worker, etc.

The importance of this program is apparent when you consider that the United Aircraft Corporation program covers some 55,000 workers, 44,000 of them in Connecticut in the plants of Pratt and Whitney Aircraft in East Hartford, Meriden, North Haven and Southington; Hamilton Standard in Windsor Locks; Sikorsky Aircraft in Bridgeport and 11,000 in the Chance Vought Aircraft plant in Texas. All of these workers are engaged in producing aircraft engines, aircraft, and other items for the national defense.

The program developed and supervised by Dr. Gallivan has received national recognition in industry as already noted. The American Legion also has awarded their National Award to United Aircraft plants in two states in two different years: namely, Pratt and Whitney Aircraft, East Hartford in 1952, and Chance Vought in Texas in 1951. The National Legion Citation reads "in recognition of the sincere appreciation of the three million members of the American Legion for its outstanding record in the employment of physically handicapped veterans."

This National Legion Citation and the National Citation of the President's Committee on Employment of the Physically Handicapped were based on the fact that of the 55,000 workers employed by the



United Aircraft Corporation over 22 per cent are handicapped.

In addition to Dr. Gallivan's leadership in modern employment practices in industry geared to the utilization of the skills and efficiency of handicapped workers, Dr. Gallivan has found time to devote his interest and efforts to civic affairs in his home community. As a part time health officer in East Hartford he reorganized East Hartford's health engineering service, has worked on the development of child health clinics and clinics for expectant mothers. He is also health director for Civil Defense in East Hartford.

He is president of the East Hartford Medical Society, member of the Board of Directors of the Hartford County Medical Association, member and past chairman of the committee on industrial health of the Connecticut State Medical Society, chairman of the insurance committee of the Connecticut State Medical Society, member of the American Medical Association, fellow in the American Academy of Occupational Medicine, member of the American Public Health Association, member of the Occupational Health Council of Manufacturers Association of Connecticut and member of the Governor's Connecticut Committee for the Employment of the Physically Handicapped.

Dr. Gallivan: it is a real pleasure on behalf of the President's Committee on Employment of the Physically Handicapped to present you with this well merited "Citation for Outstanding Service." The Certificate reads as follows:

"U. S. Department of Labor, Washington, D. C.  
The President's Committee on National Employment  
of the Physically Handicapped Awards  
this

Citation for Outstanding Service is conferred upon  
JOHN N. GALLIVAN, M.D.

In recognition of outstanding efforts expended in promoting equal opportunity in employment for the physically handicapped. Attested to by the Committee on Employment of the Physically Handicapped for Connecticut.

September 3, 1953  
Washington

For the President:  
/s/ Ross T. McIntire  
Chairman, Vice Admiral, M.C.  
U.S.N. Retired

## The Connecticut Program

ARTHUR V. GEARY, Secretary

Governor's Connecticut Committee for Employment of the Physically Handicapped

I greatly appreciate the opportunity of having a part in the presentation here today of the "Citation for Outstanding Service" from the President's Committee on the Employment of the Physically Handicapped to Dr. John N. Gallivan.

There are several reasons for my special interest in this occasion. First, of course, it is a pleasure to have a part in doing honor to Dr. Gallivan whose practical service has led to the placement in gainful employment of many thousands of physically handicapped persons, not only in Connecticut but in other states.

A second reason is that it gives me an opportunity to express my personal and official appreciation and gratitude to the Connecticut State Medical Society for their helpful assistance to the Connecticut State Employment Service and the Veterans Employment Service over a long period of years.

The fact that Connecticut has been recognized as a leader in the development of selective placement procedures for the employment of handicapped persons in suitable jobs has been largely due to the whole hearted interest and cooperation extended by your Society and its members. I would like to cite two instances of valuable cooperation extended by the State Medical Society: (1) the establishment after World War II through the interest and assistance of Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society, of a committee of doctors to assist the CSES and the VES in handling employment problems of job seekers which involved medical information, advice and assistance. (2) The publication in the CONNECTICUT STATE MEDICAL JOURNAL—June 1947—of an article on Selective Placement written by my then assistant, Vincent P. Hippolitus, entitled "Doctors Have Added Responsibilities." This article furnished information to physicians regarding the type of information which would be most valuable to the CSES and VES when physicians were called on to complete the Physical Capacities Appraisal forms used by these agencies in their joint program of selective placement of handicapped persons in suitable jobs. Sound practical information regarding the actual physical limitation, if any, of an individual job applicant covering such items as running, walk-

ing, standing, bending, climbing, lifting, finger dexterity, etc., is the basis of selective placement. This information is used to compare the person's physical abilities with the actual physical demands of the job he is seeking. Employer acceptance of handicapped workers has been developed to its present high status through this common sense approach in matching physical abilities of the job applicant against the actual physical demands of the job.

The development of this full utilization of medical science in the employment field has reached its highest point in this State, I believe, in the program of the United Aircraft which is directed by Dr. John N. Gallivan. I know the details of this program through having had the opportunity of studying its operations at the time when the Department Employment Commission of the American Legion, as a result of their study, presented Pratt and Whitney Aircraft as the concern with the most outstanding record in the employment of the physically handicapped persons including disabled veterans. Pratt and Whitney was awarded the National American Legion Citation of Appreciation in 1952. Some figures showing the results of Dr. Gallivan's leadership in this program might be interesting and amazing to those who are not aware of the advances in industrial medicine and its value to the handicapped, to their families and their communities. In August 1952, of the 22,165 employees of Pratt and Whitney (over 40 per cent of them war veterans) at their East Hartford plant 4,921 were handicapped or 22.2 per cent of all Pratt and Whitney workers. The scientific and practical program developed and directed by Dr. Gallivan led to the full utilization of the skills and abilities of these employees so that they are efficient productive profitable employees and not considered as handicapped at all—because they are not handicapped in efficiently handling the carefully selected jobs to which they are assigned.

In closing I would like to again express my appreciation to the Connecticut State Medical Society and its members for their assistance and cooperation in the development of the effective program now operating in this State through various agencies, organizations and employers, including the ones in which I have a direct connection; namely, the VES, the CSES, the American Legion and the Connecticut Committee for the Employment of the Physically Handicapped. I would like also to congratulate Dr. Gallivan on this well earned national recognition through the Citation of the President's Committee.

## LETTERS TO THE EDITOR

### Not All Need Angiography

85 Jefferson Street  
Hartford 14, Connecticut

December 10, 1953

To the Editor:

In the recent October issue of this JOURNAL, in summarizing the handling of subarachnoid hemorrhage, Dr. Whitcomb made the following statement—"If subarachnoid bleeding is found, patient should be hospitalized without delay at the nearest neurosurgical center and placed on the critically ill list, despite how well he may appear clinically. Cerebral angiography should be carried out. From this point on, each case must be handled as an individual problem, and rule of thumb does not apply."

With the last sentence I would agree, but I beg to differ with the concept that every patient who has blood in the subarachnoid space should be considered as a candidate for surgical treatment—whether an intracranial procedure or carotid ligation in the neck—until bilateral angiograms fail to reveal an aneurysm. In a study of 313 cases of subarachnoid hemorrhage at the Johns Hopkins Hospital over the past 25 years (excluding trauma, birth injury, tumor and intracerebral hemorrhage in patients over 50 years old), 171 were of unknown origin (55 per cent); 126 were proven due to arterial aneurysm (40 per cent). In another series of 143 cases at the Montreal Neurological Institute, from 1938 to 1948, 56 were of undetermined cause (32 per cent); 30 were due to ruptured aneurysm (21 per cent). While it is true that the recent extensive use of angiography demonstrates a greater percentage of aneurysms, the fact remains that subarachnoid bleeding is often obscure, both as to the type of vascular lesion and its site. This is particularly true in the elderly age group known to be arteriosclerotic where the rupture or oozing may take place through an atheromatous weakness in the vessel without true saccular or "berry" aneurysm formation.

It would seem that the current intense interest and publications of neurosurgery in the technique, first of demonstrating, then of trapping, clipping or ligating, and even dissecting and excising the lesion



has come to monopolize the therapeutic approach to this problem. Generally speaking, the young individual is the one who is likely to have an aneurysm that may be helped by surgery and at the same time not be harmed by angiography. The exact reverse holds true for the older patient.

In the current issue of the *Journal of Neurosurgery*, a paper by Rowbotham et al emphasizes the dangers of cerebral angiography. Of 430 patients subjected to this procedure, 33 had postoperative hemiparesis, of whom the neural dysfunction was permanent in 12 and death occurred in 3. In a series of 147 angiograms reported in 1951 by Dunsmore, Scoville and Whitcomb from the Department of Neurosurgery of the Hartford Hospital, there were 14 complications of which 8 were major (5 per cent), including 3 deaths and 4 permanent paralyses. These authors stress the importance of selection of cases and avoiding the older age group having thrombotic tendencies or other evidence of impaired cerebral circulation.

It would appear then that there is a chance that about one out of three patients will have subarachnoid bleeding of unknown origin. The aneurysm in a goodly number of the remainder will escape detection by even the best present technique of angiography. The aneurysm, even if located, may be so situated as to defy handling by the most skilled surgeon, utilizing the newest techniques including the aid of hypotensive drugs. If proximal ligation in the neck is resorted to as the method of choice in treating an aneurysm of the carotid artery in its cavernous or cerebral portion, this appears to be a fairly benign procedure based on a recent follow-up study of Black and German. They found 27 living out of 35 treated over a period of 16 years at the New Haven Hospital. Only six of the survivors were over 50 at the time of ligation.

Taking all these factors into consideration, it is my considered opinion that the average patient above age 50 who survives the initial stage of subarachnoid hemorrhage may have as good and perhaps better chance with conservative medical management, including careful spinal drainage under manometric control, than if he is hurriedly and often excitedly transported to a distant hospital to be

subjected to the rigors of angiography in an attempt to prove or disprove the presence of an aneurysm which is not very likely to be amenable to surgery. This statement is made without meaning in any way to belittle the recent brilliant achievements of neurosurgery in this field. But as Hamby aptly put it some time ago, this kind of surgery is big game hunting. It still is; the quarry is elusive.

Sincerely yours,

James C. Fox, Jr., M.D.

## A Medical School For Hartford?

San Marino, California,

November 23, 1953

To the Editor:

The letter of my old friend Michael Shea in the November issue interested me. He stresses three important points: (1) the probable shortage of physicians by 1960, (2) the lack of general practitioners, and (3) the difficulty and expense of enlarging existing medical schools to meet this situation. As he points out there are now seven (7) medical schools in the country which train only first and second year students and have enrolled 561 students. He suggests, to meet the emergency, the setting up of institutions to train only 3rd and 4th year medical students. He names certain large cities which have well known hospitals as proper places to do this, including Hartford, Connecticut.

While this is not an ideal solution I would like to support Dr. Shea's contention that it is a workable one. The Hartford Hospital is a large institution, it has an excellent staff and there are many well trained and competent physicians in Hartford outside of the regular hospital staff who could be called on to help if needed. Furthermore, within walking distance of the Hartford Hospital is the Institute of Living whose staff could be called on for aid in instruction regarding the psychoses and neuroses. If we have schools teaching only the first half of the medical course I can see no logical reason why we should not also have those which teach only the second half.

Yours very sincerely,

(signed) George Blumer

# AMA CLINICAL SESSION

ST. LOUIS

DECEMBER 1-4, 1953

Attendance breaks no records — Ten on hand from Connecticut — Scientific program pointed for G P — Three dimension x-rays demonstrated — Mr. Cocci — Kentucky doctor chosen General Practitioner of the Year — President McCormick urges housecleaning at local level — Chester Keefer on hand — Resolution on death of Dr. Howard — Physicians demand earlier information on new drugs — Chiropractors treating cerebral palsy — Where does "Rehabilitation" belong? — Back dues — Jenkins Keogh bills — Voluntary insurance plans — Membership classifications — Medical care of military dependents — Moulton Commission — American Medical Education Foundation — Intern matching plan — Nonservice connected disability cases — Physicians owning pharmacies — National blood program — Hospitals in practice of medicine — Chicago chosen for June 1956 meeting.

The Seventh Annual Clinical Session of the American Medical Association which took place in St. Louis the first week in December 1953 might be characterized as one of quiet dignity and of intensive work on the part of exhibitors and delegates and scientific speakers. Lacking was the glamour of such leaders as Robert Taft and Oveta Hobby, the friendly greeting from the Canadian Medical Association Secretary, Dr. Routley, and the emotional outbursts of Admiral Boone pleading for the VA medical residency program. Neither did the attendance break all records for previous clinical sessions. At the end of the second day, barely more than half way, the registration was 2,350 physicians, over 2,795 guests, bringing the total to 4,145. Final registration was expected to total approximately 7,500, including about 2,700 physicians. This was better than the previous clinical session in St. Louis in 1948, about the same as the 1951 session in Los Angeles, but less than the 1952 session in Denver. The Committee on Arrangements deserve praise for smooth sailing, both in the arrangements for the House of Delegates at the Jefferson Hotel and also in the efficient management at Kiel Auditorium where were housed all the exhibits and where the scientific program was carried out.

## Scientific Program

About 150 papers covering every important disease encountered by the family physician were presented by outstanding physicians at the general and section meetings. Two panels discussed the effectiveness of various methods of attacking cancer, especially in reference to pain relief. New hormones in gynecology; maternal complications after birth; detection, treatment and prevention of cancer of the

## CONNECTICUT REGISTRANTS

Thomas P. Murdock, Meriden—Member, Board of Trustees.

Stanley H. Osborn, Hartford—Member, Council on Constitution and By-Laws.

Norman H. Gardner, East Hampton—Member, Council on Rural Health.

Ralph M. Tovell, Hartford—Lecturer on "The Care of the Patient on the Operating Table" in scientific session on surgery.

Thomas J. Danaher, Torrington—Member, House of Delegates.

Oliver L. Stringfield, Stamford—Member, House of Delegates.

Stanley B. Weld, Hartford—Member, House of Delegates and Reference Committee on Hygiene and Public Health.

Robert D. Baird, New Milford.

Donald E. Tinkess, Greenwich.

Robert T. Zanes, Jr., New Haven.

uterus; prolonged labor in childbirth; recent developments in the treatment of rheumatic fever and nephritis with emphasis on prevention; antibiotic therapy; the prevention and treatment of virus infections—all these were included in the program. One panel discussed coronary heart disease and angina pectoris and another considered lung diseases.

## Television and Motion Pictures

A television program was carried on for four days over a closed circuit from St. Louis City Hospital to Kiel Auditorium. One of these presentations showed how radioactive isotopes are used to localize



brain tumors. None of these televised programs could be picked up on home receivers. Then there were medical motion pictures, most of them in color, demonstrating such subjects as congenital malformations of the heart, antituberculosis drugs in the medical and surgical treatment of tuberculosis, intra-articular injections of hydrocortisone, and a preliminary demonstration of 3-D x-rays, the first such in the middle west.

### Scientific Exhibits

Special features of the session were the symposium on traffic accidents which combined the experience of the police, the Safety Council, and the medical profession, and the symposium on diabetes which included an extensive exhibit under the direction of the Boston and St. Louis groups. The various exhibits on cardiac disease, especially those showing the results of surgery on stenotic valvular disease, the surgical correction of interatrial septal defects, and the surgical treatment of mitral valve diseases were outstanding. Very attractive was the exhibit portraying the therapeutic equipment used in the treatment of cerebral palsied patients and of interest was the exhibit on "The Physician in Child Accident Prevention" by a former intern of the Hartford Hospital, George M. Wheatley, now vice-president of the Metropolitan Life Insurance Company. There must always be a joker in every pack and this time it was the exhibit on "Ballistocardiography as an Office Procedure" by a Dr. I. E. Buff of Charleston, West Virginia. Not contented with demonstrating his oscilloscope, he proceeded to increase the fears and phobias of the introspective doctor and to cause the more impervious to raise an eyebrow with his warnings of the dire outcome which all of us face because of the ravages of coronary heart disease. No doubt this exhibitor will be among the missing at future sessions.

### Technical Exhibits

Little new could be found in the technical exhibits. If anything the number of proper shoes for infants and children and modernized bras is on the increase. The cigarettes lines were in evidence this session for the last time as the reading physician has demanded and is getting a purge from AMA publications of all tobacco advertising beginning January 1, 1954. So much for the "Doctor, be your own judge . . . try this simple test," "Make your own thirty day test," "Proof with one puff," and

"Not a cough in a carload." Perhaps they will be back before many years and we would welcome them if they would stick to cigarettes, etc., and leave medicine and the doctor out of the picture. There was one exhibit which was entirely new. Abbott Laboratories had caged up and on exhibit Mr. Cocci, a weird looking protozoan-appearing gentleman who was supposed to represent a composite of all the organisms known to the medical world, at least to the Abbott contingency. Motion in the technical exhibit catches the eye, hence the 1954 models should produce more activity. Sealy Mattress' back rubbing woman should not be alone in the limelight with Mr. Cocci and we hope others will follow.

### House of Delegates

This year the Speaker surpassed all his predecessors in attaining a number of refinements which added to the ease with which the House operated. Not only were the delegates furnished with tables on which to write and folders to hold their material, but copies of all resolutions introduced were furnished each delegate, if not by the time they were introduced, at least before action was taken on them. This created much favorable comment and the Speaker, James R. Reuling of New York, received the congratulations due him for his foresightedness.

#### GENERAL PRACTITIONER OF THE YEAR

Almost the first action of the House was the selection of Joseph I. Greenwell of New Haven, Kentucky as the General Practitioner of the Year. Dr. Greenwell is 80 years old and in addition to his long years of practice in a very rural area he was mayor of New Haven for 14 years, a member of the town's Board of Trustees for 25 years, and has been acting health officer for his county for the past 8 years. Dr. Greenwell was on hand to receive the gold medal and citation from AMA President, Edward J. McCormick.

#### PREIDENT'S ADDRESS

Dr. McCormick in his address to the House of Delegates outlined the progress made since the last session in New York City, but he warned that there has been little change in the federal government's trend toward socialism, cited a need for better methods of communicating medical-economic problems to the individual physician, and called on other professions and vocations to clean their own houses. This latter point no doubt followed upon the recent

smear campaign against physicians in lay magazines, notably *Colliers*. Dr. McCormick was very forceful. He said our relations with the public are not good, that we need stronger grievance committees and an expulsion of those who violate the Code of Ethics and that this should be accomplished at the local level. It is a grass roots problem. Our economic problems are not solved. Federal handouts have increased—a pernicious system—and other organizations should demand the same ethics as does medicine. Many physicians and laymen know very little of the unselfish devotion of the councils and committees of the AMA. We need newer techniques to bring the knowledge of this to our members. How many read the Organization Section of the *Journal of the AMA*? And finally Dr. McCormick pleaded for the formal teaching of medical ethics in our medical schools right now.

#### THE NEW SPECIAL ASSISTANT TO MRS. HOBBY

Chester Keefer of Boston received a great hand when presented as the new Special Assistant to Mrs. Oleta Culp Hobby, Secretary of the Department of Health, Education and Welfare. Dr. Keefer outlined in considerable detail the problems within his scope and the program contemplated by his department. Medicine may rightly be proud that a physician of such outstanding ability has been selected for this important post and has found it possible to accept the honor.

#### RESOLUTION ON DEATH OF DR. HOWARD

Your delegates presented the following resolution on the death of our own Joseph H. Howard and it was adopted by a unanimous vote.

Whereas, In the death of Joseph H. Howard, M.D. of Bridgeport, Connecticut in September of this year American Medicine has lost one of its most courageous and enthusiastic statesmen and the medical profession of Connecticut a leader of outstanding ability, and

Whereas, Dr. Howard, an eminent gynecologist and obstetrician, was a member of the House of Delegates of the American Medical Association for the past eight years, a past president of his county and state medical societies and many allied organizations where his counsel and judgment were sought during all the thirty years of his membership in organized medicine; therefore be it

Resolved, That the House of Delegates of the American Medical Association in session in St. Louis

December 1 to 3, 1953 expresses its deep sense of loss in the death of Dr. Howard; and be it further

Resolved, That a copy of this resolution be sent to the family of the deceased.

#### ETHICAL ADVERTISING

Very few controversial issues were presented to this session of the House of Delegates but there was much food for thought and some for action. One resolution from West Virginia urging that the House of Delegates and the Board of Trustees of the AMA "give consideration to measures which will insure complete conformity of all therapeutic claims with those recognized by the appropriate official authorities of the AMA" and "that steps be taken to strengthen the facilities for the detection and evaluation of all toxic reactions to therapeutic agents" brought forth considerable discussion in the reference committee hearings. As a result the reference committee brought in a recommendation that the Council on Pharmacy and Chemistry use every means possible to supply physicians with all available information on each new drug as soon as it is produced, even before it is advertised or presented to the Council for consideration. The House passed this resolution which should be of considerable help to the physician in securing more up to the minute information on new drugs now supplied largely by the detail man.

It was voted not to seek any change at this time in the federal narcotic law permitting extension of the oral prescription classification to mixtures and compounds of potentially dangerous opium derivatives.

The House voted to request the Board of Trustees to institute some means of procuring accurate information on the training in chiropractic and natureopathic schools as this is becoming an urgent need for some state medical societies in their legislative battles against the cults. It was also brought out that in Columbia, South Carolina the chiropractors are about to take over the entire treatment of cerebral palsied children through the crippled children's organization there and with the backing of the Grotto, a Masonic body. The house therefore condemned the chiropractic treatment of these cases and pointed out the need for more vigilance at the local level to prevent such situations developing.

#### WHERE DOES "REHABILITATION" BELONG?

Three resolutions were introduced relating to the term "rehabilitation." A fourth resolution brought



order out of chaos and was adopted. By this action the Board of Trustees has been requested to appoint a committee composed of representatives of the various specialties most directly concerned with rehabilitation to study the issues raised and to report to the next House of Delegates meeting in June 1954 with recommendations relative to the following questions:

1. Should the Council on Physical Medicine and Rehabilitation be reorganized and renamed to indicate more clearly a primary function having to do with the investigation, standardization, and certification of medical equipment, apparatus and materials?
2. Should another Council be formed properly representative of the various branches of medicine which are concerned with rehabilitation, such Council to be named, "The Council on Rehabilitation"?
3. Should the Section on Physical Medicine and Rehabilitation be renamed the "Section on Physical Medicine"?
4. Should the American Board of Physical Medicine and Rehabilitation be renamed?

#### BACK DUES

It was voted that to become reinstated as a member of the AMA, once membership has been forfeited because of nonpayment of dues, it will be necessary to pay up only the dues for the first year of arrears in addition to the current year.

#### JENKINS-KEOGH BILLS

The House of Delegates reaffirmed its support and endorsement of the voluntary pension program provided in the Jenkins-Keogh bills and its strong opposition to the extension of compulsory coverage of physicians under title II of the Social Security Act. The reference committee report adopted by the House said:

"The purpose of these bills is to eliminate the discrimination and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self employed persons under Title II of the Social Security Act."

#### DOCTOR DRAFT LAW

The same committee report urged continued action to obtain passage of the Bricker Amendment (S.J.Res. 1) and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. It also opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955.

The report said that "your Committee feels strongly that there should be no further extension of the Doctor Draft Law. We feel that the legislation is discriminatory and urge the Committee on Legislation and the Board of Trustees to actively oppose any further extension."

#### VOLUNTARY INSURANCE

Attention was called to the fact that a total of 91,667,000 Americans were protected against the cost of hospital care at the end of 1952, a 7 per cent increase over 1951. More than 73,161,000 were insured against the costs of surgical expense, a 12 per cent increase during the year. Medical expense protection was enjoyed by 35,797,000, a 29 per cent increase over 1951, and 689,000 persons are now protected by "catastrophic" insurance, a relatively new form of coverage.

The House passed a resolution requesting the Council on Medical Service to proceed with a special study of the problem of coverage under voluntary plans for catastrophic or long continued and highly expensive illness and of plans for a retirement fund program for citizens on small incomes not eligible under present existing public or private plans.

The House of Delegates also voted to condemn all insurance contracts which classify any medical service as a hospital service. In doing this it reaffirmed all its past actions relating to this subject. This action came as a result of information received to the effect that Health Service, Inc., a capital stock casualty insurance company reported to be wholly owned by the Blue Cross Commission of the American Hospital Association, has issued contracts to employees of the meat packing industry and their dependents in violation of the principles established by the AMA. In addition to this, Medical Indemnity of America, Inc., an insurance company said to be owned and controlled by Blue Shield Medical Care Plans, Inc., and Health Service, Inc. are operated under an agreement whereby each insurer assumes

half the risk underwritten by the other. Here we find the ghost of anesthesiology, pathology, radiology and physiatry stalking again under the cloak of hospital coverage.

#### EMERGENCY CALL SYSTEMS AND GRIEVANCE COMMITTEES

Emergency call systems have increased more than tenfold since 1948. Six hundred medical societies now have grievance committees and of the larger societies 83 per cent are so supplied. It is hoped that all the larger county and city societies will set up such committees in 1954.

#### CLARIFICATION OF MEMBERSHIP CLASSIFICATIONS

There exists among some constituent associations of the AMA a confusion in terminology and membership privileges. This problem was discussed extensively in the *Journal of AMA*, November 28, 1953. As this is a very recent issue it should be readily available to all of our members and it is therefore recommended that you consult the above issue of *Journal of AMA* and familiarize yourself with the contents of the article entitled "Development of Uniformity in Membership Regulations Between Constituent Associations and AMA."

#### MILITARY MEDICINE

The Board of Trustees was directed to study the question of federally subsidized scholarships for prospective military personnel and to support the principle of the same if action becomes necessary before the next session of the House of Delegates convenes.

Approval was extended of the principles and practices outlined in current disaster policies of the Red Cross for the handling of the medical features of disaster relief. These policies have been published and are available.

#### DEPENDENT MEDICAL CARE

Medical care for dependents of service personnel has been the subject of considerable study by the Trustees and at least two of its Councils. The AMA is opposed to the present method of providing medical care for dependents of service personnel because it operates to the detriment of the community medical program, it requires unnecessary and exceedingly costly expansion of medical military facilities producing an artificial shortage of medical and allied health personnel. The House adopted the following policy:

(a) That Congress be urged to carefully consider and fully define a national policy with respect to the provision of medical care for dependents of service personnel.

(b) That the Association advocate that any program devised for the care of dependents of military personnel be made contingent upon the adoption of a clear and understandable definition of what constitutes a dependent.

(c) That the Association continue to recognize the need and importance of utilizing military medical personnel and facilities in providing hospitalization and medical care for dependents of service personnel residing outside the continental United States, and at or near military posts in the United States where civilian facilities are unavailable or inadequate.

(d) That except in situations as outlined in (c) above, the Association recommend that medical care and hospitalization of the dependents of service personnel be provided by civilian personnel in civilian facilities; and

(e) That the Association approve of the principle of premium payments by service personnel through the media of non governmental insurance agencies to cover the cost of medical and hospital care of their dependents through voluntary payroll deductions.

In addition to the above the House of Delegates went on record in disagreement with the substance of the recommendations of the Moulton Commission (Citizen's Advisory Commission on Medical Care of Dependents of Military Personnel). This Commission was believed to have been given insufficient time to investigate the many complex problems and issues involved in the provision of medical care for dependents of service personnel and it failed to take cognizance of the broad social implications of this problem and the fact that a perpetuation or an extension of the present program transcends the interests of the Department of Defense. The House voted to recommend that the newly established Hoover Commission be requested to consider the subject of dependent medical care, that the matter be thoroughly and exhaustively studied and that Congress be supplied with complete background and statistical information, as well as a discussion of the broad implications of the program, so that a sound national policy can be established.

#### AMERICAN MEDICAL EDUCATION FOUNDATION

The income realized by the American Medical Education Foundation in 1952 for the first time



passed the million dollar mark, reaching \$1,174,000. The number of physicians contributing more than doubled last year. Physicians have given to the medical schools of our country over one and three-quarter million dollars. The Board of Trustees of AMA plans to give another \$500,000 to the Foundation in 1954 bringing to a total of \$2 million the contribution of the AMA to the medical schools. The Board will not be in a position to continue this annual contribution indefinitely and urges continued and increased support by individual physicians and by organizations in medical and allied fields.

#### INTERN TRAINING PLANS

The delegate from Rhode Island introduced a resolution to abolish the matching plan for internships. Since this has been found successful in almost 90 per cent of hospitals and students and since the House believes that the small nonteaching hospitals are just as well off under this plan as they were before its inception, it rejected the resolution.

The Council on Medical Education and Hospitals was directed to revise and republish its listing to include all hospitals accredited but not subscribing to the Matching Plan in the same master list with those accredited for intern training and using the Matching Plan.

#### NONSERVICE CONNECTED CASES

An attempt was made to pass a resolution which would act through the deans' committees and regulate medical attention rendered to veterans in VA hospitals for teaching purposes by limiting to those cases of service connected origin only. This was defeated. This was the only resolution relating to the controversial subject of nonservice connected disability cases in VA hospitals introduced into this House of Delegates. Regional conferences are now being held throughout the United States to (1) develop a working liaison with state association veterans committees, (2) discuss methods for carrying out the instructions of the House of Delegates, (3) increase the number of physicians who have a working knowledge of the policy and the facts relating to it, and (4) learn the situation in each state. Veterans organizations are castigating the American Medical Association for its opposition to treating nonservice connected cases in VA hospitals. The medical director of the Veterans Administration adds his voice to the uproar on the grounds that his medical residency program will be disrupted.

Tennessee has proposed a plan whereby the veteran could purchase insurance coverage from any insurance company of his own selection operating in his area and approved by the VA and be reimbursed by the federal government. This so-called Tennessee Plan has not been accepted by the AMA House of Delegates. Meanwhile the struggle continues.

#### PHYSICIANS OWNING PHARMACIES

In the report by the Judicial Council attention was again called to the ruling by this Council that it is unethical for a physician to have a financial interest in a pharmacy in the area in which he conducts his professional activities and where he profits directly or indirectly from the sale of devices or remedies prescribed for his patients. The Judicial Council also has ruled that the rental of space to a pharmacist in a clinic or office building owned or leased by physicians is unethical if the space is rented on a sliding scale or for a percentage of the income received.

#### NATIONAL BLOOD PROGRAM

Organization of a proposed National Blood Foundation was approved at the last session of the House of Delegates in June 1953. This organization has not been completed as yet but the Board of Trustees is continuing its efforts as directed by the House of Delegates.

#### UNETHICAL PRACTICES

The House approved a revision of one section of the Principles of Medical Ethics of the AMA which clarifies the relationship of physicians to all forms of public information media. The revision had been worked out by the Council on Constitution and By-laws.

In an effort to solve the publicity problems resulting from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study all aspects of the problems. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June 1954 meeting in San Francisco.

#### JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

To clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of

General Practice in a hospital, the House adopted the following resolution:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article or series of articles, in the *Journal of the American Medical Association* and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, by-laws and their interpretations, and

"That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

#### HOSPITALS PRACTISING MEDICINE

Three resolutions were introduced relating to the old subject of hospitals practising medicine. For these was substituted a resolution which was adopted with instructions to follow "Guides for Conduct of Physicians in Relationships with Institutions" adopted by House of Delegates at Los Angeles in December 1951. This will be found in our own JOURNAL, issue of January 1952.

#### JOINT BILLING TO PATIENTS

A resolution introduced by the Iowa State Medical Society, calling for approval of a joint billing procedure involving services rendered by two or more physicians, was referred to the Judicial Council, at the suggestion of the Reference Committee on Miscellaneous Business, with the recommendation "that the Judicial Council investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

#### TODAY'S HEALTH

The Board of Trustees reported a deficit of \$150,000 for *Today's Health* during the year ending August 31, 1952. It was called to the attention of the delegates that if every member of the American Medical Association subscribed to this worthwhile publication the deficit would soon be wiped out.

#### JUNE 1956 MEETING

It was voted to hold the 1956 Annual Meeting in Chicago the week of June 11-15. Hereafter the place of meeting will be selected five years in advance instead of three as at present.

#### ANNUAL SESSIONS

1954 San Francisco, June 21-25.

1955 Atlantic City, June 6-10.

1956 Chicago, June 11-15.

#### CLINICAL SESSIONS

1954 Miami, November 30 - December 3.

1955 Boston, November 29 - December 2.

### State Medical Journal Conference a Success

Editors and business managers of the various state medical journals came to AMA headquarters on November 9 and 10 for the '53 State Medical Journal Conference. With a total registration of 131, representing publications from Maine to Hawaii, the two day seminar offered a wide coverage of subjects. Of particular interest to the editors and their assistants were talks by Paul de Kruif, Dr. Julian P. Price, Fred C. Sands of the Schering Corporation, and Prof. Paul D. Bagwell, head of the department of communications skills, Michigan State College.

The business representatives gave careful consideration to the ideas presented by Dr. Austin Smith; R. Blayne McCurry of Abbott Laboratories; William T. Coulter of Bruce Publishing Company; Alfred J. Jackson, who made a general report on the State Journal Advertising Bureau; Kenneth B. Butler of the Butler Typo-Design Research Center, and Gilbert S. Cooper of the AMA specialty journals, who suggested new techniques which will doubtless be reflected in several of the journals.

Highlight of the Monday evening session at the Hotel Knickerbocker was the talk given by Kenneth McFarland, Topeka, Kansas, educational consultant and lecturer for General Motors.

Dr. L. Fernald Foster, Bay City, Michigan, was chairman of the program which was conducted by other members of the S.J.A.B. advisory committee.

Noteworthy among the many letters of appreciation directed to Mr. Jackson, as director of the S.J.A.B., were those from new personnel of the journals. They have been frank in saying that as a result of the conference they gained a better perspective for their own publications.

Connecticut was represented by Clair Rankin and Stanley B. Weld, both of Hartford.

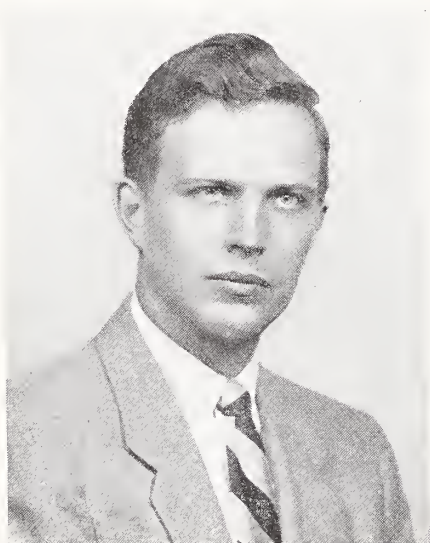


## MEDICAL STUDENT SCHOLARSHIP AWARDS

The first awards to be granted by the Society under a new scholarship program for medical students were announced at the semi-annual meeting of the House of Delegates, December 10.

The three recipients of the awards, all fourth year medical students are Richard M. Demko, Rockville; Francis Hobson, Plainville; and Michael L. Fezza, New Haven.

Mr. Demko received his academic degree at the University of Connecticut in 1949 and is now com-



RICHARD M. DEMKO



FRANCIS HOBSON

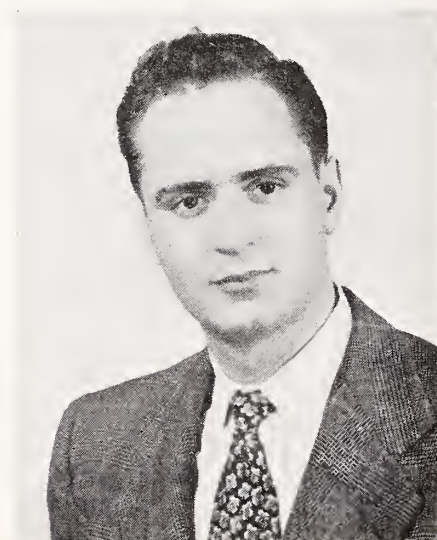
students at an approved medical school and be recommended for scholarship consideration by the Dean of their school, a Connecticut physician and another resident other than a relative.

Information concerning the program was sent to all approved medical schools in the United States and Canada last September, at which time November 15 was set as the final date for acceptance of applications.

The program is similar to another scholarship activity announced by the Society last fall, when scholarships were awarded to three student nurses.

pleting his medical education at New York University College of Medicine. A graduate of Plainville High School and J. C. Smith University, Mr. Hobson is a fourth year student at Meharry Medical College, Nashville, Tennessee. Mr. Fezza has studied medicine at New York Medical College since September, 1950. He graduated from Yale University in 1949 and attended the Yale Graduate School prior to entering medical college.

The scholarships are in the amount of \$500 each and the three recipients were selected from a group of 48 applicants, all residents of Connecticut now completing their medical education. Requirements for applicants stipulate that they must be fourth year



MICHAEL L. FEZZA

## State Medical Society Joins in Automobile Accident Research Program

Connecticut physicians are to play a leading part in an intensive research program to track down the specific causes of injury in automobile accidents.

The Council of the State Medical Society has appointed a three member advisory committee to cooperate with the Crash Injury Research Institute of Cornell University Medical College in furthering the Connecticut study, to be supervised by Mr. Hugh DeHaven, director of the Institute.

Dr. Harold A. Bergendahl, Norwich, has been named chairman of the Society's committee and its members are Dr. Paul W. Vestal, New Haven, and Dr. George Crawford, Centerbrook.

The Connecticut State Police also will cooperate in the study, which will be patterned after similar studies now under way in three other states: Indiana, Maryland and North Carolina.

Researchers will pay special attention to data indicating that injury was caused by structural or design hazards in the vehicle rather than by actual collision. And a major aim of the program will be to make this information available in ways that can aid automotive designers, engineers and manufacturers to increase safety factors.

In Indiana, where the first phase of the program has been completed, it was found that many persons killed in automobiles might have lived had they been protected by better design of car parts and accessories.

The study brought a conclusion that hazards might be greatly reduced if drivers and passengers wore safety belts and it is reported that the cars of the Indiana State Police already have been equipped with them. This is experimental, however, and Mr. DeHaven emphasizes that the value of such belts can be determined only by thorough testing under all kinds of driving conditions.

The importance of obtaining medical data is stressed by Mr. DeHaven, and the cooperation of physicians is considered highly essential for success of the research program.

In Connecticut, as in the other states joined in the project, report blanks will be mailed to physicians to aid in assembling injury data. The four page forms contain outlines of the human figure and physicians

will be requested to indicate thereon the location of accident injuries, no matter how trivial, and regardless of whether or not a fatality occurred.

"Remarks concerning possible disfigurements or disabilities will be of exceptional value," the program director points out. Physicians are therefore urged to include such information and also to make any comment thought pertinent to accident research.

While automotive designers and manufacturers are deeply concerned about safety design, Mr. DeHaven explains that they have no way of assessing the hazards that may pass from drawing boards into production without study of well correlated accident data.

But there are no such statistics currently available. And when it is considered that approximately 900,000 passenger accidents occur every twelve months, the need for the present research program is strongly spotlighted.

Crash injury studies already completed show that needless and excessive injuries frequently occur at speeds as low as twenty or thirty miles an hour. These have been caused by improperly designed windshields, door latches, instrument panels, seats and accessories. In one case, although damage to the vehicle amounted to less than fifty dollars, a passenger was thrown out and killed because a door popped open from the impact.

These and other results have pointed the way to the framing of questions for the current study. Among the most important questions researchers will seek to resolve are the following:

In what percentage of accidents do doors pop open?

What area of the body is most frequently injured?

Which causes more injuries: car rolling over, side-swipe, head-on collision?

What objects and structures inside car are most likely to cause fatal or serious injury?

Are some steering assemblies safer than others?

"When the right answers are found and applied to car construction," Mr. DeHaven says, "there is no doubt that the automobile of the future will be far safer than it is today. However, there are many difficulties in collection of information for the study. A large volume of data is needed to assess current dangers and the safety needs for the future."



## MILITARY AFFAIRS

### COMMITTEE ON MILITARY AFFAIRS

COLL. B. GIBSON, Meriden

STANLEY B. WELD, Hartford

HAROLD SPEIGHT, Middletown

#### No Doctor Draft Needed After 1955, U. S. Officials Agree

Present Defense Department planning envisions no extension of the doctor draft beyond July 1, 1955, but instead it calls for a program of "fence mending" and "belt tightening," federal officials concerned with the law stated at the annual meeting of the Association of Military Surgeons. This position was outlined at the same time that Dr. Edward J. McCormick, president of the American Medical Association, told the surgeons: "It is our belief that this is a most propitious time for devising a program which will clearly eliminate any need for this legislation well in advance of July 1, 1955."

Dr. Melvin A. Casberg, Assistant Secretary of Defense (Health and Medical), said steps taken or planned to stimulate regular medical officer procurement include study of law to provide medical scholarships to students commissioned in the armed forces following graduation. He said, however, that this will create a problem: "All Indians and no chiefs." It is the duty of civilian organizations, he said, to aid the military in procuring more experienced doctors for teaching and training posts in the services.

Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, recommended a further reduction in the physician-troop ratio, from a projected 3.2 to 2.9, as one form of belt tightening. If the size of the armed forces does not increase, he believes it should be possible to meet requirements after mid-1955 from each year's graduating classes. In the meantime, however, drafting of doctors will resume late next summer or early fall, he said, with possibility that as many as 1,250 Priority III doctors in their early 30s will have to be called during the life of the act.

Dr. McCormick also made these points: (1) the problem of medical care for military dependents should be turned over for study to the Hoover Commission on government reorganization, with final determinations by Congress, (2) meanwhile there

should be improved utilization of military medical personnel and curtailment in non professional duties, (3) in the event a universal military training program is voted, then pre-professional and professional education for qualified students should be continued.

#### Military Promotion Regulations Changed

Some medical reserves will benefit from a change in Defense Department's directive on the revised doctor draft act. Under the first directive issued October 7, only experience prior to acceptance of a commission counted in determining whether the officer was entitled to a higher rank under the new law. The effect of the change is to credit all experience up to the time the officer goes on active duty. Under the previous interpretation, a number of men were in effect penalized in grade for the two or three years spent in the reserves prior to going on active duty. The new regulation means higher grades for some men when they are called up and promotions for others already on active duty.

#### Military Group Recommends More Dependent Medical Care

A 5 man committee of admirals and generals named by the Secretary of Defense last spring believes that a serious deterioration of career service can be halted only by such things as higher military pay and more medical and dental care for dependents. The report was made public a day after Assistant Secretary of Defense John Hannah warned that the services were losing career men in numbers "so great as to be disturbing." He, too, cited low military pay and a "continual nibbling away at fringe benefits."

The study group, headed by Rear Admiral J. P. Womble, Jr., put the blame for decline in fringe benefits on "pressure groups of business interests" and "congressional economy attacks." The report said benefits must be fully restored, must be declared by law to be a part of service pay, and in some cases must be increased. It defined benefits as hazardous

and incentive duty pay, sea and foreign duty pay, medical and dental care for dependents, better and cheaper housing, and better provision for education of service children.

In making the report public, Mr. Hannah said it would receive careful consideration from the military services, the Defense Department and the Joint Chiefs of Staff. He added that its release did not imply "approval or acceptance" by the department "in every respect."

## Draft Policy Restated on Hospital Residents

National Advisory Committee to Selective Service, whose chairman (Dr. Rusk) and members function also as ODM's Health Resources Advisory Committee, has issued a restatement of policy on deferment of hospital residents. Those who are in Priorities I or II should be considered available for military service and nothing done to prevent classification in 1-A, says the memorandum. As for Priority III's (non veterans), recommendations are as follows:

Double liability registrants (subject to both the regular and doctor-draft laws) should volunteer for military duty upon completion of internship and are not to be considered for residency appointments.

Those special registrants who are under age 31 but not vulnerable to the regular draft should be tagged "available" upon completion of current internship or residency training.

"The committee . . . has repeatedly called attention to the fact that an individual's potential liability for military service should be considered in appointing residents. This applies also to the so-called pyramid system; those individuals selected for advancement to an additional year's service as they rise in the pyramid should be those who are not liable for military service. It is essential that the hospitals cooperate in this program. . . ."

From the blue ribbon panel of discussants came the symposium's more philosophic tones. Dr. Chester S. Keefer, of Department of Health, Education and Welfare, deprecated the doctors-per-thousand approach as unrealistic, in which the doctor of medicine is some kind of standardized unit. In military as well as civil practice one can not ignore such factors as specialization and distribution, he said. Let us take a long range point of view and, instead of battling statistics, take whatever steps may be needed

to increase overall supply of doctors and ancillaries.

Dr. Morris Fishbein came out for full government control of medicine in time of emergency. Dr. Paul R. Hawley did not go that far but he gave out a warning that when and if this country is attacked, there will be no time for bickering over doctoring in uniform vs. doctoring in mufti. "It will be just one great big problem and the people who'll be safest will be those in the armed forces," he said.

## Navy Data Show Extent of Care of Dependents

November issue of the monthly "Statistics of Navy Medicine" contains an informative paper on scope of dependent care by that military branch. It is based on a special survey conducted last January. It covered activities of 2,708 medical officers performing clinical services, of whom 632 were found to be caring for dependents and 260 for other non military patients, including veterans and retired civilian employees. Two-thirds of the time of doctors assigned to dependents was taken up with outpatient care.

## Higher Ratio in Hospitals

Out of the grand total (Korea excluded) of 2,708 "full time equivalents utilized in active professional duties," 2,072 were on duty within U. S. continental limits. Of latter number, 1,265 were in hospital assignments and 389 of them, or 31 per cent, were associated with dependency care. Two specialties, obstetrics and pediatrics, accounted for 172 of the 389. Greatest volume of outpatient care of dependents was recorded at naval dispensaries in San Francisco and Washington.

## Defense Department's Scholarship Legislation is About Ready

Defense Department's draft legislation for medical and other federal scholarships is receiving a final checking over before presentation to the Budget Bureau for approval. Budget Bureau approval is necessary if the plan is to be presented as an administration bill, but regardless of the bureau's action, the proposal could be offered by any member of House or Senate. Essential provisions of the plan:

1. Any medical, dental, nursing, or veterinary student accepting a scholarship would be obligated



for one year of federal service for each scholarship year. 2. Payment would be made directly to the schools for tuition and other incidentals and to the student to cover living expenses during the school year. 3. Scholarships, limited to four years, would not be offered to premedical students or others preparing for professional courses. 4. Deans would make recommendations, but final selection would be by the Defense Department.

According to a department spokesman there are two objectives: First, to meet armed forces needs after expiration of the doctor draft in 1955, if the regular draft obligation does not produce enough officers. Second, to interest enough young officers in regular military careers to maintain the regular corps at the necessary level. Currently regular medical officers make up only about 25 per cent of the medical corps total; it is hoped to reverse this ratio.

### **Dr. R. A. Kern New Head of Medical Consultants**

Society of Medical Consultants to Armed Forces held eighth annual meeting in Washington recently. Dr. Richard A. Kern, of Philadelphia, assumed the presidency, succeeding Dr. John Minor, of Washington. Dr. Worth B. Daniels, of Washington, was elected vice-president; Dr. George Eaton, Baltimore, secretary, and Dr. Donald Pillsbury, of Philadelphia, treasurer. Members adopted certain undisclosed recommendations for transmittal to offices of Surgeons General.

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### **Appointed to National Board**

Creighton Barker, executive secretary of the Society and since 1941 secretary to the Connecticut Medical Examining Board, has been appointed a member of the National Board of Medical Examiners. In the nearly forty years of the existence of the Board, Dr. Barker is the second Connecticut physician to be a member, the other was Stanhope Bayne-Jones, then professor of bacteriology and one time dean of the Yale Medical School. Immediately after appointment Dr. Barker was named chairman of the Board's Committee on State Board Relations. Dr. Barker is ex-president of the Federation of State Medical Boards of the United States, a member of the AMA Committee on Evaluation of Foreign Medical Schools and has made medical school evaluation surveys in Denmark, Sweden and Norway.

### **Yale University Has New Department Head**

Charles L. Buxton is the new Professor of Obstetrics and Gynecology and Chairman of the Department at Yale University School of Medicine. He is at present a member of the faculty of the College of Physicians and Surgeons, Columbia University, but will leave his New York post and join the faculty at the Yale School of Medicine in April, 1954, where he will succeed Herbert Thoms who retired last June after serving on the Yale faculty for 31 years. In addition to his Columbia post, Dr. Buxton has been on the staff of the Sloane Hospital for Women in New York since 1934 and the attending obstetrician there since 1951.

Born October 14, 1904 in Superior, Wisconsin, Dr. Buxton received his Bachelor of Science degree from Princeton in 1927 and his M.D. degree from Columbia in 1932. In 1940 he received the Doctor of Medical Science degree, also from Columbia.

He was an intern in surgery at the Mary Imogene Bassett Hospital, Cooperstown, New York, in 1932-33, and a research fellow in anatomy at Harvard in 1933-34. He went to the Sloane Hospital in 1934 as an intern in obstetrics and gynecology. He became a resident there in pathology in 1935-36, in obstetrics in 1936-37, and in gynecology in 1937-38.

He became the assistant attending obstetrician and gynecologist at Sloane Hospital in 1938, promoted to associate status in 1947 and then to the top attending rank in 1951. In addition, he has been the supervisor of the Sloane Sterility and Endocrine Clinic since 1939.

Dr. Buxton joined the Columbia University faculty as an assistant professor of Obstetrics and Gynecology in 1938, and was promoted to associate professor of Clinical Obstetrics and Gynecology in 1947. He has been a full professor there since 1951.

During World War II, Dr. Buxton served in the medical corps of the U. S. Navy, and was stationed at Annapolis and later in the Pacific theatre. He was released from service with the rank of commander.

He has been a consultant for the Knickerbocker Hospital in New York since 1952 and the assistant secretary of the New York Obstetrical Society, also since 1952. He is a former chairman of the section on obstetrics and gynecology of the New York Academy of Medicine, a diplomate of the American Board of Obstetrics and Gynecology, and a member of the editorial board of the *Journal of Clinical Endocrinology*.

## INFORMATION CREATES CONFIDENCE

Informing people about the extensive activities sponsored by medical associations in the public interest invites trust and confidence.

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## PUBLIC RELATIONS

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#### Connecticut's First Medical Forum

The first Medical Forum to be held in Connecticut attracted an audience of more than 500 community residents when it was presented in Greenwich, Monday evening, November 23.

The forum, a public discussion by physicians on health problems and medical care, was sponsored by the Greenwich Medical Society, the Greenwich Health Association and Greenwich Hospital.

Dr. Gray Carter, chief of staff at Greenwich Hospital, was moderator and physician members of the panel were Howard P. Serrell, chief of surgery; Jane Lockwood, chief of medicine; Robert P. Rogers, chief of pediatrics; and Payson B. Ayres, acting chief of obstetrics and gynecology. Members of the panel were introduced by James A. Linen, chairman of the Health Association's fund drive.

Following an introductory talk by Dr. Carter, in which he outlined the progress of medicine and scientific research, members of the panel answered questions submitted by the audience.

The questions touched upon major advances in surgery, use of cortisone, importance of weight control during pregnancy, the effects of gamma globulin in poliomyelitis, the meaning and effects of Rh positive and Rh negative blood factors, and how to choose a family doctor.

The forum was the first in a series being planned by the sponsoring organizations as a community health education project. It is patterned after the forum, "You and Your Health," sponsored by the Pinnellas County Medical Society, St. Petersburg, Florida, where the idea originated. Its success there encouraged the development of a similar series of forums in Atlanta, Georgia, where they have been equally successful, and a growing number of local professional and health associations have been encouraged to advance similar projects for their communities.

#### New Leaflet for Hartford County Residents

"Let Your Doctor Be Your Guide" is the title of an attractive leaflet to be published by the Hartford County Medical Association for distribution to community residents.

The booklet will stress the importance of periodic health examinations, how to select a family physician and the availability of emergency medical care through the association's 24 hour telephone service.

#### TV Code to be Implemented

Dramatizations that portray physicians in commercial television programs are to receive closer attention by the National Association of Radio and Television Broadcasters.

A close liaison was recently established between the broadcaster's organization and the American Medical Association to institute corrective action when programs conflict with code provisions.

The code adopted by the broadcaster's association provides: "When dramatized advertising material involves statements by doctors, dentists, nurses or other professional people, the material should be presented by members of such profession reciting actual experience or it should be made apparent from the presentation itself that the portrayal is dramatized."

The code further provides that "a television broadcaster should not accept advertising material which in his opinion offensively describes or dramatizes distress or morbid situations involving ailments, by spoken word, sound or visual effects."

"Because of the personal nature of the advertising of medical products, claims that a product will effect a cure and the indiscriminate use of such words as 'safe,' 'without risk,' 'harmless' or terms of similar meaning should not be accepted in the advertising of medical products on television stations."

The American Medical Association has requested the cooperation of physicians and others in reporting transgressions of the code so that corrective action can be initiated.

### Controversy — A Danger Signal

From the standpoint of good public relations, it is important to avoid hasty comment on controversial issues and this is particularly true in matters that affect medicine, John L. Bach, press relations director of the American Medical Association, emphasized in a guest editorial for the November issue of the *Indianapolis Medical Society Bulletin*.

"Think—Then Count Ten," was the title of Mr. Bach's editorial, in which he commented: "What you, as a member of the medical profession, have to say about these issues is important from the standpoint of molding public opinion. Think before you speak for publication and be doubly sure that what you say is based on facts, not on hearsay or rumor . . ."

"In speaking for publication, especially off the cuff, there is one important thing to remember: controversy breeds discussion—and discussion promotes reader interest. That is what every business publication, whether it is a newspaper or magazine, is chiefly interested in from an economic standpoint—reader interest. The more controversial the issue, the more reader interest it attracts."

In this and other relationship problems, the author pointed out, it should be realized that "Good public relations cannot be conducted alone from a central office; it must reach out from the office of every doctor in the land."

### Ruling on AMA Dues Passed by House of Delegates at St. Louis Meeting

**RESOLVED**, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.

## THE DOCTOR'S OFFICE

Francis W. Delligan, M.D. announces the opening of an office for the practice of radiology at 36 Woodland Street, Hartford.

Anderson W. Donan, M.D. announces the opening of an office for the general practice of medicine at Westover Road, Simsbury.

Haik Kavookjian, Jr., M.D. announces the opening of an office for the general practice of medicine at 179 Noroton Avenue, Noroton.

Donald J. McCrann, M.D. and Morgan V. Flaherty, M.D. announce the removal of their offices for the practice of obstetrics and gynecology to 36 Woodland Street, Hartford.

Charles E. McLean, M.D. announces the opening of an office for the practice of cardiology at 85 Jefferson Street, Hartford.

George F. Parton, Jr. M.D. announces the opening of an office for the general practice of medicine at 715 Burnside Avenue, Hartford.

### Connecticut Physician Honored in Michigan

Mackinac Island Michigan was the scene recently of special ceremonies honoring one of Connecticut's most illustrious physicians, William Beaumont. It was in 1822 that Dr. Beaumont carried out his analytical studies on Alexis St. Martin which earned for him the epithet, "Father of Physiology." Michigan physicians and civic organizations have contributed funds for the erection of a shrine on Mackinac Island to be completed next year. Dr. Beaumont's office at Mackinac Island as it appeared in 1822 when it was a trading post also will be restored and become a part of the shrine.

William Beaumont was born and raised in Lebanon, Connecticut. In the early 20's he was caught in the migratory wave sweeping the eastern seaboard, moved to Champlain, New York and then to St. Albans, Vermont, in which latter place he studied medicine under Dr. Benjamin Chandler. His experiences in the U. S. Army gave him his opportunity to carry out his epoch making experiments on the physiology of the stomach.

Connecticut has honored Dr. Beaumont in many less dramatic ways than Michigan.



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## NEWS FROM WASHINGTON

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### Manion Commission Panel Starts Survey of U. S. Grants

A panel of consultants to the Manion Commission has started a national sampling survey to "determine the composite impact of all federal aid programs in the state and local fields where the service is rendered." It will look into all programs where both federal and state or local funds are used, including vocational rehabilitation, grants for crippled child work and for the disabled and several other activities of medical interest.

On the basis of findings of the survey, and information from other sources, the commission expects to recommend changes designed to limit federal participation and stimulate more activity by the states and local communities.

The survey will involve only four or five states in five general areas of the country. According to the commission, it is the first time this technique has been applied to the problems of federal-state relationships.

Members of the commission are Arthur E. Buck, West Norwalk, Connecticut, an authority on public budgeting; Phillip Cornick (PH.D.), Chicago, a governmental research consultant; Edward Litchfield, Ithaca, N. Y., dean of the School of Business and Public Administration, Cornell University; Herbert Simpson (PH.D.), Evanston, professor at Institute for Economic Research, Northwestern University

### John W. Tramburg of Wisconsin Heads Social Security Administration

John W. Tramburg, a 40 year old Wisconsin Republican, is the new administrator of the Federal Social Security Administration. He is chairman of the Council of State Public Assistance and Welfare Administrators and since 1950 has been director of the Wisconsin Department of Public Welfare. The social security post has been vacant since the resignation earlier this year of Arthur J. Altmeyer. Mr. Tramburg will serve on an interim presidential appointment until the Senate acts on his nomination. Mr. Tramburg will be responsible for the Bureau of

Old Age and Survivors Insurance, the biggest (\$1.4 billion) operation in the Department of Health, Education, and Welfare. All but a fraction of the funds go for grants to states for OASI payments, and crippled children and public assistance programs.

Pending in Congress is an administration recommendation that OASI be extended to 10 million more persons, including physicians. If Congress should enact such controversial laws as free hospitalization for the aged, waiver of OASI premiums for disability, or permanent and total disability pensions, they would also be administered by Mr. Tramburg's agency. These proposals have been made in the past, but have been defeated each time by Congress.

### Internal Revenue Rules on School Movie Taxes

Two rulings issued by Internal Revenue Service relate to tax on admission tickets for lectures or entertainments whose proceeds go to educational institutions or hospitals. Advice had been sought whether it was necessary to tax tickets for a lecture illustrated with movies, which was for benefit of a scholarship fund. Although the institution involved is tax exempt, it was held that the lecture tickets were taxable because program included motion pictures. Had the lecturer used slides instead of movie film, there would be no tax.

The other decision concerns the privately operated, nonprofit hospital that receives financial support from Federal, state or local government (for example, Hill-Burton aid). Admission tickets for benefit of such institutions are not taxable. Provided, that is, program does not consist of movies—or pugilism, wrestling, sports contests or exhibitions featuring professional performers.

### APA Group Will Certify Mental Hospital Chiefs

Washington headquarters of American Psychiatric Association announces it has formed a committee to certify physicians as "qualified mental hospital administrators." Dr. Francis J. Braceland, Hartford, Connecticut, heads the committee. According to

APA, it will conduct examinations and issue certificates to successful candidates. To qualify, applicants must be adequately trained in psychiatry and skilled in business and personnel management, budget, purchasing and other administrative techniques.

Serving with Dr. Braceland are Drs. W. B. Terhune, New Canaan, Connecticut; George W. Jackson, Topeka; W. H. Baer, Peoria, Illinois; G. L. Jones, Williamsburg, Virginia; Frank F. Tallman, Los Angeles; Arthur M. Gee, Essondale, B. C., Canada; H. W. Sterling, North Little Rock, Arkansas; Jack R. Ewalt, Boston; G. Wilse Robinson, Kansas City, Missouri. Certification forms and information may be had from committee secretary, Dr. C. N. Baganz, manager of Veterans Administration Hospital, Lyons, N. J.

## Federal Trade Commission Actions

FTC CUTS CLAIMS FOR SUN LAMPS, ARCH AIDS

Federal Trade Commission announces approval of stipulations that will result in modification of medical claims for sun lamps and arch supports. Cincinnati firm of Sperti Faraday, Inc., will stop advertising that use of its lamps promotes body resistance to colds. Scholl Manufacturing Co., of Chicago, will stop representing that its foot aids are universally indorsed by medical profession and that they are useful in relief of varicose veins. The Commission's complaint against Institute of Applied Hypnology, New York, disputes advertised promises that its mail order course in hypnotism qualifies graduates to treat epilepsy, obesity and alcoholism. The Commission has issued a complaint against the Dahlberg Co. of Minneapolis; FTC says the firm's advertising of a "tru-sonic canal earphone" fails to reveal potential dangers to the ear.

## WHO Committee Urges National Mental Health Units

The World Health Organization's Expert Committee on Mental Health strongly recommends that each member government set up a special division to deal with the organization of mental health services on the national level. "Without such central representation it will prove very difficult to stimulate the development of mental health work throughout

the country," the group states. The committee also has agreed on the "essential characteristics" of the modern psychiatric hospital. Its suggestions now go to the 18-member executive board for decision on whether to publish the report as a WHO document.

The committee lists among the essentials: (1) the psychiatric hospital should be designated by a town planner on the model of a small village with 25 to 30 patient units split into groups of not more than 10; total capacity should range from 300 to 1,000 beds; (2) a hostess, endowed with intelligence and an attractive personality should receive the patients; (3) the personality of the patient should be respected; (4) the psychiatric nurse should be a specialist technician and should not be obliged to attend more than 3 to 6 patients; (5) patients should be encouraged to form themselves into clubs.

## Details Told of Study of Tobacco and Cancer

Veterans Administration and Public Health Service will collaborate in a forthcoming study which, it is hoped, will settle question of relationship between tobacco consumption and incidence of lung cancer. Details were told at American Cancer Society symposium in New York by Harold F. Dorn, PH.D., chief of biometrics, National Institutes of Health (PHS). This winter some 350,000 veterans, majority of them age 55 and upward, will receive a questionnaire requesting information on smoking habits—cigarette, cigar and pipe—and use of chewing tobacco or snuff. Return of a quarter million executed questionnaires is anticipated.

Most of veterans in this survey will be holders of government life insurance, facilitating collection of statistical data on causes of death. Mortality expectancy of the survey group is about 5,000 a year. In three to four years, according to Dr. Dorn, a clear picture should begin to emerge on influence of tobacco as a possibly culpable agent.

Veterans Administrator Harvey Higley will urge veterans to cooperate in the study, through medium of a personal message accompanying questionnaire. Note: As has already been reported, American Cancer Society has well under way its own mass survey of smoking as a factor in the incidence of lung cancer.



## FROM OUR EXCHANGES

"Replacement Therapy Versus Occupation Therapy With Adrenal Steroids in Liver Disease" is based on reliable evidence of an adrenocortical deficiency in diseases of the liver (*Amer. Pract.*, 3:12). The treatment of these diseases with ACTH and cortisone has yielded equivocal results. It is the considered opinion of Pelnar and Waldman that this inconsistency is to be found in the extremely high doses of the hormone that are commonly used. By replacement therapy is meant the use of just enough hormone to make up for the deficient amounts in the body.

The "replacement" dose of cortisone has been arbitrarily taken by the authors as the amount that would be suggested for treatment of a patient with Addison's disease. This is stated as about 25 mg. daily.

The authors report in detail on three cases of liver disease (hepatitis) treated on this plan with favorable results. They believe that the differentiation of hormonal treatment into two distinct dosage levels is of considerable theoretical and practical importance.

\* \* \* \*

"The Present Status of the Ballistocardiogram" is discussed in considerable detail by Starr in the November issue of *The Annals of Internal Medicine* (37:5). For those physicians who are unfamiliar with this method of studying cardiac strength and weakness the article is recommended for reading. We judge that the ballistocardiogram is still in the exploratory stage as to its ultimate usefulness. Dr. Starr makes no claims as to its present utility either in making a diagnosis or in determining the future functional competency of the heart. The findings are interesting and must be interpreted in the knowledge that this subject (ballistocardiogram) is still in its infancy.

\* \* \* \*

John J. Connelly, the presiding justice of the Boston Juvenile Court, believes that "Children Are Not Expendable." (*New Eng. Jour. Med.*, 248:1.) He enquires into the possibility that our schools place too much stress on the attempt to make school pleasant and attractive to children. He thinks that

the idea of school as a discipline has been abandoned, probably owing to the efforts of believers in so-called progressive education. The incidence of delinquencies in recent years indicates in his opinion that it might be more salutary to subject all children to more rigid control and less "freedom," "self expression" and "natural development."

Judge Connelly does not minimize the importance of religious influences, of the solemn obligation of those who direct the dissemination of information and entertainment to realize their responsibilities nor of the wisdom that lies in the idea that parents should reindoctrinate themselves with the natural virtues of kindness, sincerity, tolerance and truth. The guiding of our children to a successful maturity is the greatest challenge in a parent's life. In normal times it is not easy; in times of crisis it is most difficult.

\* \* \* \*

"The Physiological Effects of Operations for Duodenal Ulcer" (Smithwick, *Rhode Island Med. Jour.*, XXXVI:2). Problems in surgery are apparently rarely discussed. The conclusions that the author arrives at are of practical importance. Recurrence of the ulcer does not occur, according to the author, if achlorhydria is present in the fasting stomach, following a potent food stimulus and after vagal stimulation. He concludes that the only operation that can be depended upon to consistently produce achlorhydria are those involving at least the distal one-half of the stomach together with the vagus nerves. The size of the gastric remnant seems to have a close relationship with the more serious untoward side effects of the operation for duodenal ulcer. The best clinical results are obtained by those patients having the largest gastric remnants. It appears probable that in the light of the physiological effects of hemigastrectomy combined with resection of the vagus nerve this operation will supplant subtotal gastrectomy as the operation of choice. The author ends on a note of caution to the effect that a follow-up of an adequate number of carefully studied cases is needed to demonstrate the superiority of any given operation in the management of duodenal ulcer problems.

Atkinson believes that the early diagnosis of poliomyelitis is important from the standpoint of the prevention of paralysis (*Jour. Tenn. State Med. Assoc.*, 46:2). Cases diagnosed within 48 hours after onset showed a high percentage of non paralytic cases in comparison with those diagnosed at a later time. The reason for the more favorable results lies in the fact that complete rest was instituted almost from the beginning of the disease. The author favors treating poliomyelitis locally and preferably in the home.

\* \* \* \*

Martin concludes that cancer of the tongue is again becoming a surgical problem (*N. Y. State Jour. Med.*, 53:2). For a time cancer of the tongue has been considered to be a problem in radiation but in recent years it has been returned to the surgeon, and particularly that part pertaining to neck dissection.

The results of surgical treatment are not ideal, but are superior to the results of radiation therapy and especially with regard to cervical lymph nodes. Carcinoma of the posterior third of the tongue is frequently of a highly undifferentiated type and still responds better to competent radiation than to surgery.

Cancer of the tongue does not always follow a logical course of progression. In the author's opinion complete excision or destruction of the primary carcinoma with subsequent bilateral dissection of the cervical lymph nodes appear to offer the patient with cancer of the tongue the best chance of survival.

\* \* \* \*

Accidents now have a foremost rank as a cause of death in late infancy and childhood. ("Accidental Death—A Challenge to the Modern Pediatrician" by Forbes. *Tex. State Jour. Med.*, 49:3.) An awareness of the problem is the first step in any program of prevention. Much can be done to prevent accidents in children. Perhaps accident prevention can be summed up in the single word "education." Furniture design, the care of poisons, the danger of leaving small objects around that may be ingested or inhaled and the teaching of the small child of the inherent dangers that are concealed in many of our modern conveniences are effective methods of approaching the problem. The modern child is literally "surrounded by lethal weapons."

Harris makes the statement that "the intelligent use of intestinal decompression by intubation and suction has been one of the most important factors in the reduction of the mortality rate associated with bowel obstruction," ("Intestinal Intubation in Bowel Obstruction," *Jour. Internat. Col. Surg.*, XVIII:4.) The term "small bowel distension" best describes the type of case in which intubation therapy is indicated. In selected cases, particularly in the presence of postoperative adhesive obstruction, definitive successful results may be obtained in 80 to 90 per cent of the cases treated.

Complications of intestinal intubation are comparatively minor, and methods for prevention and treatment of such complications are described in some detail. Briefly the complications described are failure to pass the tube through the pylorus and difficulty in withdrawing the tube. If the tube cannot be withdrawn and fails to pass through the rectum an exploratory laparotomy and enterostomy are indicated. The contraindications for an intestinal intubation are (1) strangulating obstruction, (2) vascular obstruction, and (3) obstruction of the large bowel. There is danger of persisting in intubation therapy when surgical intervention should be employed, and contraindications to continuing such therapy are emphasized in this article.

The three most common long intestinal tubes in use today are the Miller-Abbott, the Harris and the Canter.

\* \* \* \*

Root and West consider "The Increasing Incidence of Coronary Arteriosclerosis in Diabetes Mellitus" (*Jour. Okla. State Med. Assoc.*, 46:1). The high incidence of myocardial infarction in diabetics is due mainly to an acceleration of the rate of coronary sclerosis. The increased frequency of obesity and hypertension favors myocardial infarction. Renal infection accounted for 8.5 per cent of the deaths in the author's group of diabetics. Emphasis is placed on the importance of the discovery, prevention, and aggressive treatment of urinary tract infections. The course of juvenile diabetes is different from that of the adult. Death is usually due in children to nephropathy, tuberculosis and diabetic coma, while in adults the chief causes of death are coronary sclerosis and cancer.



"The Significance and Management of Acute Spontaneous Thrombophlebitis in the Superficial Veins of the Lower Extremities" is considered by Lowenberg in the October issue of *The Journal of the International College of Surgeons* (XVIII:4). The spontaneous onset of thrombophlebitis in the superficial veins of the lower extremities may indicate: (1) thrombophlebitis in varicose veins; (2) superficial thrombophlebitis with concomitant deep vein thrombophlebitis; (3) Buerger's disease; (4) migratory phlebitis; or (5) malignant disease.

The author recommends immediate surgical intervention. There should be included in the operation a high ligation of the saphenous vein and stripping and resection of the varicosities in the affected limb. The acute thrombophlebitis is not infectious and is not considered a contraindication to such surgical treatment. When the thrombophlebitis in the saphenous vein has ascended to the saphenous-femoral junction, safe ligation requires thrombectomy.

Every case of thrombophlebitis of the surface veins may be complicated by a similar process in the deep veins. Evidence of the deep vein process may be minimal. There should be an exploration in all cases of both the saphenous and the femoral vein.

The author recommends regional heparinization as an adjuvant to venous thrombectomy. He includes in his paper on spontaneous superficial thrombophlebitis case reports of such an accident as a manifestation of Buerger's disease, of migratory phlebitis and of latent malignant disease.

\* \* \* \*

"The Results of the Bialock-Taussig Operation in 200 Cases of Morbus Caerulus" have been studied by Campbell and Deuchar (*Brit. Med. Jour.*, 4806.) Most of their cases had Fallot's tetralogy and in these cases the results were good. Many were seriously ill, but only 8 per cent died and 75 per cent benefited greatly. A smaller number of the series suffered from complex lesions, such as tricuspid atresia, dextrocardia and pulmonary atresia. In this last group the results were less good, the total mortality being nearly 30 per cent and only 35 per cent obtaining good results.

There was a total of 200 anastomotic operations in patients having morbus caerulus. The improvement, when it occurred, is noted as loss of much of their cyanosis, clubbing and polycythaemia and an increased capacity for exercise. Special attention

was given to the size of the heart as this has been considered a drawback to the operation. Generally the increase in the size of the heart was not great and was not progressive after the first few months.

\* \* \* \*

Tracheotomy in chest injuries is indicated if there is respiratory distress (cyanosis, moist rales, stridor), inability to cough effectively, hemorrhage into the trachea or bronchi, and if there is prolonged coma with aspiration of salivary and pharyngeal secretions (Von Leden, *Ill. Med. Jour.*, 104:3).

The author calls attention to the fact that a correctly performed tracheotomy is a harmless procedure and that it carries with it no additional risks for the patient with respiratory obstruction. Adequate postoperative care is essential for the maintenance of a patent airway. Team work is called for in the treatment of crushing chest injuries. It is usually possible to avoid respiratory obstruction with pulmonary complications and asphyxia if a laryngologist is permitted to supervise the problem of airway maintenance. In serious chest injuries a tracheotomy can be a lifesaving procedure.

\* \* \* \*

"The Early Diagnosis of Cancer" is interestingly—and too briefly—discussed by Bamforth (*Practitioner*, 1023:171). Biopsy remains the most common procedure in determining early malignancy. The author points out the importance of obtaining a piece of tissue for histological examination that is sufficient and fully representative. There are certain exceedingly difficult physical conditions which can be diagnosed by a critical examination of the blood and smears from marrow puncture (multiple myelomatosis is cited as an example). Cytological examinations have commanded an increasing interest during recent years. Malignant cells in the sputum, in the pleural and peritoneal fluids, vaginal smears, the stomach washings, the urine and prostatic smears, all on occasions yield significant information.

It can be added that certain procedures have been instituted during recent years which may be employed for the examination of large numbers of people that have by accident or design brought to light many cases of early cancer. Mass radiography, for example, used for the early detection of tuberculosis of the lung has been responsible for the discovery of a small number of pulmonary neoplasms.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Dewey Katz, Hartford*  
*President-Elect, Mrs. Newell W. Giles, Darien*  
*Second Vice-President, Mrs. Winfield Kelly, Norwich*

*Recording Secretary, Mrs. Walter Nelson, Cromwell*  
*Corresponding Secretary, Mrs. Stevens J. Martin, Hartford*  
*Treasurer, Mrs. Norman J. Barker, Collinsville*



MRS. LEO J. SCHAEFER

### Semi-Annual Meeting

Mrs. Leo J. Schaefer, president of the Woman's Auxiliary to the AMA, was guest speaker at the semi-annual meeting of the State Auxiliary on November 10. She spoke of the recognition and appreciation which doctors' wives throughout the country are receiving for their participation in such projects as the National Polio Foundation, the Crusade for Freedom, Civilian Defense and Mental Health.

A president's pin, designed by Mrs. N. Marinaro of Hartford County, was given to Mrs. Dewey Katz and all the past presidents of the Auxiliary: Mrs. H. B. Lambert, Mrs. James R. Miller, Mrs. James D.

Gold, Mrs. R. J. Cook, Mrs. Charles Goff, Mrs. Ralph Gilman, Mrs. Winfield Wight, Mrs. F. E. Tracy, Mrs. Barnett Freedman.

Dr. Thomas M. Feeney thanked the guests for their contributions to the State Medical Society and to doctors in general. He stressed the need to remain aware of attempts to bring socialized medicine into being.

Mrs. Truda Kashmann directed a dance recital celebrating the Auxiliary's ten years of activity. It portrayed the projects involving medical and nursing scholarships, public relations, school health and rural health. Mrs. Paul L. Phelps of Canton was the narrator, Miss Rachel Saul, the vocal soloist.

"Live" decorations of ivy and grapes lent a beautiful and unusual atmosphere to the luncheon tables. A birthday cake alight with ten candles was carried to the head table and small individual birthday cakes, each with a lighted candle, were served to the guests.

A fine C.D. display was set up in the lounge. Mrs. E. Roland Hill reminded members to be finger printed and to obtain their blue C.D. cards.

At the business meeting a nominating committee was elected, composed of Mrs. Willard Buckley, Middlesex County; Mrs. John Bucciarelli, Fairfield County; Mrs. Everett Allen, New Haven County; Mrs. James R. Miller, Hartford County and Mrs. Joseph Woodward, New London County.

### Annual Conference

It was my privilege to attend the 10th annual Conference of Presidents and Presidents-Elect in Chicago, November 18-20. Mrs. Schaefer opened it and Mrs. George Turner, national president-elect, directed the proceedings. Its theme was "Know Your Community. Serve Your Community." It was pointed out that awareness of the needs of people is not enough unless something is done to alleviate conditions.



The subjects discussed on Wednesday and Thursday were American Medical Education Foundation, Legislation, Civil Defense, Nurse Recruitment, Mental Health, *Today's Health*, Rural Health and Organization. National chairmen acted as moderators with state presidents participating in the discussions and members of the AMA staff serving as guest speakers.

Mr. Hiram Jones brought out the aims and accomplishments of the A.M.E.F. and the continuing need for professional medical workers as well as doctors, stressing the part the auxiliaries can play in bringing the problem to community and county levels. Since it is our tradition to finance institutions of higher learning with private funds, we must not allow medical education to be legislated by Congress. Connecticut is one of five states in which all organized counties have contributed to the Foundation this year.

Mr. Joseph Stetler of the Legislation panel told us that of the 989 bills in the first session of Congress, 260 pertained to medicine. Doctors appeared 16 times before Congress.

Mrs. Dewey Katz participated in the Civil Defense panel. When Mr. Stetler spoke he commended her highly for the clear and concise method of handling her subject. In this panel the need for workers to assist physicians, courses for workers and registration with C.D. organizations were held to be of greatest importance.

Among the suggestions for Nurse Recruitment was formation of future nurses' clubs. There was much discussion concerning scholarships versus loans.

Dr. Richard J. Plunkett emphasized the importance of the classroom in mental health and said that since it is recognized that education is failing to prepare children for happy adult life, several projects have been introduced into the schools such as the Bullis, Force, Oajmen and Forest Hills Village plans. Their value has not yet been determined.

Mr. Robert A. Enlow brought forth the fact that *Today's Health* is the only authoritative medical publication for the lay public. Auxiliaries were urged to introduce a more widespread distribution of it.

The panel on Rural Health discussed the need in rural areas for doctors, preschool clinics, promotion of voluntary health plans and nutritional programs. Assistance to allied groups engaged in health service is of great importance. Mr. Aubrey Gates said that

there is in the United States a tremendous struggle to capture the support of farm groups. They backed doctors against socialized medicine and we should give them all possible assistance.

The Organization panel dealt with general suggestions for organizing auxiliaries, getting and keeping new members.

An account of the World Medical Association and its aims was given. A voluntary non government association of 700,000 physicians, it is of tremendous worth in raising health standards, disseminating information, presenting the opinion of its group to the World Health Organization and UNESCO, and in keeping the practice of medicine free by cooperating with other countries.

The history, activities and progress of the AMA were presented at the close of the panel discussions. This prepared us for our visit to its headquarters the following day at which time we toured the building and saw four AMA movies available for auxiliary meetings.

Dr. Franklin D. Murphy, chancellor of the University of Kansas, was guest speaker at Wednesday's luncheon. He discussed How to Build Health and Win Friends. On Thursday Dr. Edward J. McCormick, president of the AMA, spoke on Auxiliary Activities in the Preservation of Democracy.

It was an enjoyable experience and a rewarding one to be able to meet with women from auxiliaries in other parts of the United States, to exchange ideas and to learn how others are accomplishing their aims. I wish to thank the members of our Auxiliary for giving me this opportunity.

Emma V. Giles, President-Elect

## County News

### FAIRFIELD

We contributed \$350 to the A.M.E.F. at our fall meeting. We decided to give one rather than two nurses' scholarships this year. We will give a piano to Laurel Heights Sanatorium, the second such gift we have made to them. The Mariner Girl Scouts of New Canaan, under Mrs. Bucciarelli's direction, made 24 game boards for bed patients of Laurel Heights.

The October 10 dance netted us \$406.

At the December board meeting, we decided to investigate a scholarship for a Registered Medical Record Librarian. Letters explaining what the Fair-

field County Auxiliary had accomplished in 1953 were sent to all doctors' wives.

HARTFORD

Mrs. Irving Krall, chairman of the State's Medical and Surgical Relief Committee, secured the free use of a Red Cross station wagon to transport the material to New York City. A Hartford Auxiliary member is a Red Cross driver.

*(Continued on next page)*

**Auxiliary Praised for CD Work**

Woman's Auxiliary  
to the American Medical Association  
1953-1954 Committee on Civil Defense

November 24, 1953

Mrs. E. Roland Hill  
Civil Defense Chairman  
Woman's Auxiliary to Connecticut State  
Medical Society  
43 East Main Street  
Mystic, Connecticut

Dear Mrs. Hill:

Connecticut can be proud of itself for its fine showing in civil defense.

The Regional Conference held at Simsbury was very successful, and your work in civil defense was mentioned by the Connecticut staff.

The five auxiliary members from the vicinity of Hartford were most hospitable as well as being fine representatives of our Medical Auxiliary.

Sincerely,  
Marie L. Gale (Mrs. Julius P.)  
Eastern Regional Chairman

Members of the Woman's Auxiliary to the Hartford County Medical Association recently forwarded 58 cartons of medical samples to the Medical and Surgical Relief Committee in New York for shipment to hospitals and clinics in foreign countries.

Mrs. Irving Krall, Hartford, state chairman for the Auxiliary project, reports that similar programs are now being organized in other counties. Committee chairmen have been appointed as follows: Mrs. Joseph Petrelli, New Haven, for New Haven County; Mrs. James T. Smith, Winsted, Litchfield County; and Mrs. Ward McFarland, New London, New Lonon County.

**The Woman's Auxiliary Needs Your Wife**

Sometime in your life there has been someone who has approached you and your friends with an appeal to do something (probably when you were a youth) and when you hesitated after a stirring speech on the merits of the proposed action, the proposer ended up with an, "Aw c'mon fellers, it won't hurt." True then, it's true now—it won't hurt when you ask your wife to join the Woman's Auxiliary to the Hartford County Medical Association.

Probably the most outstanding single reason for their existence is service to you. Everything they do redounds to the benefit of the medical profession in the county area, directly or indirectly.

If they established a memorial scholarship to help young men and women pay for medical or nursing education, or if they send your unused pharmaceuticals abroad to needy countries, or if they sit by the hour stuffing envelopes or picking up urine specimens for the diabetes campaign, they are helping you.

To do a better job, to develop a better program, and to become an even more successful adjunct of HCMA, they need more members. There are 876 members in our organization, whereas the Woman's Auxiliary has only 395 (State membership 1,117). They need large numbers to meet their many tasks—for the members are mothers and wives first and must parcel out their time.

You can help the Woman's Auxiliary by telling your wife how much she is needed. You can show your wife this editorial and urge her to become a member. If she asks the advantages of membership, tell her that besides helping you and the profession, she will be associating with women who have the same social and economic backgrounds and the same individual problems. Tell her also that the Auxiliary is not all hard work, that there is entertainment also, and interest in social or economic problems, that if she wants to, she can participate in civil defense plans or take part in state or national legislation committees, or music and art committees or publicity, if she feels she has a flair for any of these. Tell her she can be a leader or a follower. For whatever she wants to be, the Auxiliary needs her.

*Reprinted from editorial page of Hartford County Medical Association Bulletin. It is applicable to all members of the State Society and to the seven County Auxiliaries.*



COUNTY NEWS (*Concluded*)

## LITCHFIELD

At the semi-annual meeting in November, Dr. Edward H. Kirschbaum of Waterbury spoke on "Community Health Activities." As a patient welfare Christmas project for Fairfield State Hospital we are raising funds for television sets for the hospital.

## MIDDLESEX

Mrs. Louis LaBella, Civilian Defense chairman, attended the Eastern Regional Conference on C.D. in Simsbury on November 5.

Mrs. F. Erwin Tracy is a member of the Eastern District Committee of the AMA Auxiliary Organization Committee.

Mrs. Louis Soreff, secretary of our auxiliary, was honored by the Congregation Adath Israel for her years of service as teacher and principal of its Sunday School.

Mrs. Henry Sherwood, chairman of *Today's Health*, reports that Middlesex County has already topped its quota. Mrs. Benjamin Roccapriore is assisting in the subscription drive.

## NEW HAVEN

Mental Health was the subject of the speaker and slides at our semi-annual meeting. A food sale was held in conjunction with this meeting to raise funds for the auxiliary. Mrs. Bensche provided a Civilian Defense display.

## WINDHAM

Mrs. Morton Arnold, chairman of the State Publications Committee, has been appointed State chairman of *Today's Health*. She replaces Mrs. Martin O'Neil who resigned.

### Orchids to Our Volunteers

There are many facets of the Connecticut Regional Blood Program which are not known to even its most ardent supporters. This Blood Program is one of the very few, and the only statewide program caring for the total blood needs of its residents. This Blood Program also provides blood plasma, frozen plasma and blood fractions for use at no cost for patients in its hospitals.

There is, however, one facet which is all too often ignored in people's thinking in this Program, namely,

the tremendous volume of work performed by the volunteers. In any bloodmobile operation, the volunteers outnumber the staff by four to one. In the Center itself approximately 5,000 man hours of work are done gladly by volunteers mainly from the Hartford Chapter and its branches. Only those who have been in close touch with the Blood Program can realize the time which is consumed in recruiting prospective donors for a single bloodmobile operation. If we add to all these hours of work performed the time consumed by volunteers who send in walk-in donors to hospitals in emergencies, we come to a staggering total.

It can be truthfully stated that this Program cannot be carried on without volunteers to whom the residents of this State owe a large debt of gratitude.

### New Council AMA Associate Secretary

Dr. Walter S. Wiggins, who has been assistant dean for graduate and postgraduate medical education at the State University of New York, Syracuse, since 1951, will join the AMA headquarters staff on January 1.

He is taking over the position of Associate Secretary of the AMA Council on Medical Education and Hospitals, replacing Dr. Francis R. Manlove, who left a short time ago to become director of the medical center and dean of the department of medicine, University of Colorado School of Medicine, Denver.

## OUR NEIGHBORS

### Vermont

Officials of the Red Cross Blood Program in Vermont and New Hampshire recently stated that their request for physicians to provide voluntary medical coverage at local blood drawings has met with a 100 per cent response. Throughout the two States, busy general practitioners and specialists alike have co-operated in this endeavor, which will result in a saving of approximately \$12,000 in the current year's Blood Program budget. Excellent progress has also been achieved in reducing the returns of outdated blood from the former figure of 20 per cent toward the objective of 10 per cent.

## Hospital Room Charges

Room charges in Connecticut's general hospitals have increased ten per cent during the past year, according to figures released by the Connecticut Blue Cross hospital plan.

The twice-a-year Blue Cross survey, based on data furnished by 32 community hospitals throughout the State, places the average hospital room charge at \$15.16 per day at the present time. This compares with \$13.78 per day a year ago.

The figures cover room, meals and general nursing care only, Blue Cross explained. Charges for special services such as operating room, x-ray, drugs and laboratory are not included in the study.

By type of accommodation, room charges averaged out this way: private room—up 9.1 per cent over a year ago to \$19.77 now; semi-private—up 10 per cent to \$15.70; private ward—up 6.5 per cent to \$12.15; staff ward—up 12.3 per cent to \$13.56.

While averages are necessary to give the statewide picture, they don't indicate the actual price structure in any one institution, the hospital plan pointed out. Regional differences and variations in the type of room provided account for a price range that goes all the way from \$7.50 per day, the lowest staff ward rate reported, to \$29 per day for the highest priced private room.

Overall, the 10 per cent increase during the past twelve months follows a general pattern of steadily rising hospital charges in postwar years, Blue Cross said. Since the 1947-49 base period, room charges in Connecticut hospitals have shown a total increase of about fifty-seven per cent.

## The Yale Psychiatric Institute

Several important changes have occurred in the Yale Psychiatric Institute, notably the appointments of Miss Elizabeth Royce as administrator, Dr. Stephen Fleck, associate professor of psychiatry at Yale, as psychiatrist in charge, Dr. Roy Schafer, formerly with the Austen Riggs Center and the Menninger Foundation, as chief clinical psychologist and associate professor of psychology in the Department of Psychiatry, and Dr. Norman Cameron as professor of psychiatry.

The supervision of the resident staff in the intensive treatment of patients will be carried this year

by Drs. Helen Gilmore, Richard Newman, Henry Wexler, Samuel Hunt and Alfredo Namnum, all of whom not only have extensive experience in individual psychotherapy but also are familiar with the activities and policies of the Institute.

In addition to the changes in personnel, some striking changes are occurring in the Institute itself. The first floor has been completely redecorated and refurnished. The rooms have been painted and decorated in a semi-modern, bed-sitting room style. Redecorating and refurbishing is beginning on the second floor and we expect to have a completely modernized and redecorated hospital by the early part of next year.

The Institute accepts all types of psychiatric patients for diagnostic evaluation and treatment. There is a particular interest on the part of the staff, however, in making the Institute a suitable place for the treatment of young schizophrenic patients.

## Hartford Hospital Breaks Record

During the year ending October 31 the Hartford Hospital admitted 33,221 patients, the largest number in its 99 years of operation. To carry on the hospital during this same year cost \$6,682,923.84. In spite of this the hospital showed a surplus of almost \$106,000 against a deficit of \$72,000 the previous year. The average patient's bill increased 9.5 per cent, due to increase in salaries, greater use of special services and techniques, and the choice of better accommodations by patients.

Two new operating rooms, an out-patient department with x-ray equipment, a new cardio-respiratory diagnostic clinic, and a gift for the purchase and installation of a modern, high power x-ray machine for deep seated cancer cases have been acquired by the hospital in the past year.

## Dr. Marvin Addresses Western New York Meeting

Dr. H. M. Marvin, president-elect of the Society, recently addressed a joint meeting of the Western New York Heart Association and the Buffalo Academy of Medicine in Buffalo. "Aortic Stenosis—Its Recognition and Peculiar Hazards," was the topic of his address.



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## OBITUARIES

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### Vincent J. Grillo, M.D.

1909 - 1953



The sudden death of Vincent J. Grillo on July 24, 1953 takes from our midst an energetic, dynamic, congenial and inspiring personality. Throughout his professional career his efforts and his devotion to medical practice were dedicated to the advancement of medical standards and to scientific progress.

His patients will miss him for his conscientious approach to their numerous medical problems. This he always maintained on a high medical plane while never lacking in personal and friendly concern for their welfare. He had a knack of always placing his patients completely at ease, promoting assurance and confidence.

His colleagues will miss him as an outstanding scholar and for his counsel and judgment of medical problems.

Dr. Grillo was born in Hamden, Connecticut on January 24, 1909. He attended Yale Sheffield Scientific School, holding the Sterling Scholarship for four years, and was graduated in 1929. He entered Yale Medical School in 1929, held the Verdi Scholarship for two years, and was graduated in 1933. His

ability and eagerness to learn made itself evident at an early age, for he was only sixteen when he was licensed a junior pharmacist. He worked as a part time pharmacist for six years during his school days which helped to lessen the financial burden upon his family.

He interned at St. Francis Hospital in Hartford, Connecticut, and following his internship he entered the general practice of medicine in Hamden, Connecticut. He was in general practice for ten years, during which time he devoted his efforts and energy unselfishly to the cause of medicine. His tireless drive and the will to acquire further knowledge plus his love of orthopedics presented him with a problem. Considerable thought and patient analysis of this problem, before making definite plans as to the future, were in order. It was not an easy decision for one with such an extremely active practice to make. On the one hand there existed a love and unceasing desire to enter a specialty which he carried in his heart through his latter years as a medical student, and then while in general practice; on the other hand, a desire not to desert his patients.

A definite decision had to be made, and though his services were to be sorely missed by his patients, he decided to give up his practice and entered the New York Orthopedic Hospital in 1945 as a resident. He remained in this capacity until 1947. During the years 1947 and 1948 he held the Annie C. Kane Fellowship at Presbyterian Hospital in New York City.

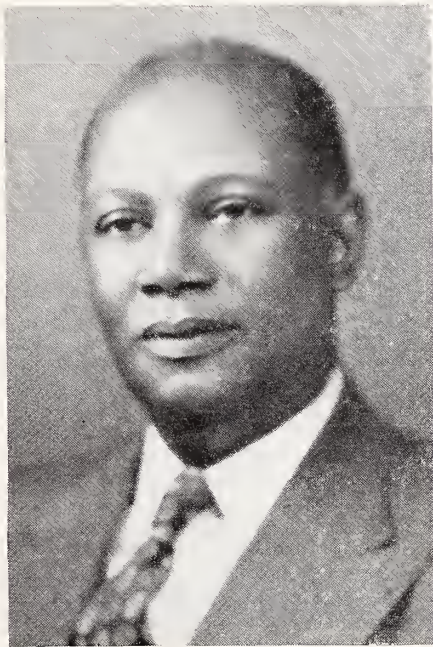
Following his return to New Haven he limited his practice to orthopedic surgery. His ability in this new field was quickly recognized by his colleagues and also by his former patients. In a few short years he developed one of the largest orthopedic practices in the State. He was appointed to the staff of the Grace-New Haven Hospital, the Hospital of St. Raphael, and to the Newington Home for Crippled Children. He built up one of the finest libraries in orthopedic surgery to be found in this area.

He is survived by his wife, Mary A. Devlin, and five children, Mary Ann 14, Vincent Jr. 13, Jean 11, Peter 9, and Patricia 3 months.

Dr. Grillo will be greatly missed by all who knew him, both lay and professional. His ability to acquire knowledge and his equal ability to impart it will long be remembered by his colleagues. He was a great champion of what he considered right and proper, and an inspiring force in the advancement of medical knowledge and skills. His many devoted patients will never forget his genuine interest and friendly understanding of their problems. All of us feel a deep sense of humility and sorrow at the passing of so great a friend and counselor.

Arthur L. Delgrego, M.D.

A. G. Boswell James, M.D.  
1896 - 1953



Dr. A. G. Boswell James died suddenly in his office on August 24, 1953 as a result of an acute coronary thrombosis. He was 57 years old.

He was born in Arouca, Trinidad, British West Indies, on March 12, 1896 and acquired his elementary education in the public schools in Port of Spain, Trinidad. During the early part of World War I he did special telegraphic war service for the Trinidad Government. In 1918 he matriculated at the Liberal Arts College of Toronto University and graduated with the degree of B.S. in 1923. His medical career began later in the year when he enrolled in the Medical College of McGill University in Montreal, Canada. In 1927 he graduated with the degree of M.D. Following graduation from Medical School he

interned at the Montreal General Hospital and at the same time studied Public Health and Preventative Medicine, receiving the degree of Doctor of Public Health from McGill University in 1929. He practiced general medicine in Montreal for a short time and moved to Bridgeport in the early part of 1930 to resume the practice of general medicine. Several years later he became intensely interested in cardiology and internal medicine and did considerable postgraduate work in that field at Montefiore Hospital and Mount Sinai Hospital in New York City. At the time of his death he commanded an extensive practice specializing in cardiac diseases.

Dr. James was a member of the Bridgeport Hospital medical staff, the American Medical Association, Fairfield County Medical Association, Connecticut State Medical Society, Connecticut Medical and Dental Association (Negro), Board of Directors of the Catholic Charitable Bureau of Bridgeport, Board of Directors of the American Red Cross (Bridgeport Chapter), United Negro College Fund, Chief of the Clinic of the Bridgeport Heart Association (affiliate of the American Heart Association).

Dr. James was endowed with a mind of great capacity which he trained and developed as opportunity afforded. All of his activities were in strict accord with the best traditions of his profession. His relations with his fellow members of the medical profession were most friendly and to many of them he gave freely of his time and counsel.

He had an abhorrence of the slightest violation of professional ethics and scorned all that is mean and petty. He considered his calling one of the noblest that society affords and he was proud to be enrolled in the ranks of those who bear its torch. His life was rich in friendships and unselfish deeds. He had gained for himself through his rectitude of living, the esteem, affection and high regard of his patients and fellow members of his profession. He was possessed of a very attractive personality and his un-failing courtesy was but the reflection of the innate kindness of the man. Courtly in his manners, he was, nevertheless, affable, approachable, tactful, considerate of the feelings of others, uniformly kind to his inferiors and dependents and gave to every man his just need of appreciation and recognition.

“His life was gentle, and the elements  
So mixed in him, that Nature might stand up  
And say to all the world,—‘This was a man’.”



The community has suffered an irreparable loss in the death of Dr. James, who not only endeared himself to his patients and to his fellow practitioners, but to all those who had the pleasure of meeting him or dealing with him.

He is survived by his widow, Alys Distin Follette James, a daughter, Carole, and a son, Ronald.

Albert Levenson, M.D.

### Edward H. Crosby, M.D.

1901 - 1953



We always take good things and competent people for granted. Only after losing them do we know how great their services were to all of us. The death of Dr. E. H. Crosby on September 14 of this year brought so many of us, his friends and working colleagues, his patients and his family, to that realization of personal loss which one can seldom fathom until actually faced with it.

Such a loss sustained by us all is compensated in part by memories of Dr. Crosby's attributes and capacities. He never refused a patient or a friend any service, great or small. As one of his close friends has expressed it, "He always cooperated in every detail . . . and did so promptly and to his best ability, which he had in great abundance."

Born in Hartford in 1901, raised and educated in the public schools of this fine New England com-

munity, it seemed only natural that he should pursue his medical education at Yale where he graduated in 1928. After an extensive general and orthopedic postgraduate training in Chicago, Albany and the Cleveland Clinic under Dr. James Dickson, Dr. Crosby completed his training at the New Haven Hospital in 1932. Very shortly he began his specialty practice in Hartford and his long association on the McCook Hospital staff. He was invited to join the orthopedic department at that hospital by Dr. James Wilson, one of Hartford's able pioneer orthopedic surgeons. Dr. Crosby was chief of orthopedics at his death. Far too many younger orthopedists had resigned from the staff, but Dr. Crosby, on the other hand, continued to carry the load which became heavier for him each year. His devotion to this institution was remarkable.

The Newington Home and Hospital for Crippled Children, the Anna Hadley Hakes Memorial Clinic in Winsted, and the Hartford Dispensary were actively served by him for many years. He was a consultant to a number of hospitals in the area, associate orthopedic surgeon at St. Francis Hospital, chief of service at Rocky Hill Veterans Hospital and shortly before his death was made chief of the Norwich Clinic of the Division of Crippled Children, State Department of Health. He was on the poliomyelitis team of the Hartford Chapter, National Foundation for Infantile Paralysis.

Following his own sense of duty he accepted a commission in the active Medical Corps of the U. S. Navy, prior to Pearl Harbor, serving throughout the war and retaining his commission as a Captain in the Reserve Corps upon returning to civilian practice in 1946. This was a long period to be absent from active practice. Upon returning he redoubled his energies, never refused anyone, and continued to pursue his abiding interest in fishing. His energy seemed inexhaustible. His death came while leaving a showing of his favorite fishing motion pictures before a men's club. He must have died with the pleasant memories of his fishing companions and the wild streams and forests where he had gone to fish, so fresh in his mind. This is as it should be.

We shall miss him every day and for a long time to come.

Charles W. Goff, M.D.

E. F. Carniglia, M.D.

J. W. Larrabee, M.D.

**Edward L. Brennan, M.D.****1900 - 1953**

Edward L. Brennan was born in County Carlow, Ireland, May 21, 1900. He attended Summerhill College and the National University in Ireland. He came to the United States in the late 1920's and joined the staff of the Vanderbilt Clinic in New York City as attending psychiatrist. He was also an instructor at Columbia University. He was brought to Hartford in 1938 by the late C. Charles Burlingame, psychiatrist in chief of the Institute of Living, and made a staff psychiatrist and later executive officer of the Institute.

In 1947 he organized the outpatient clinic at Saint Francis Hospital and it remained under his direction until his untimely death on September 27, 1953. In addition to his private practice and the work mentioned above, he was also attending psychiatrist at the Veterans Hospital, Northampton, Massachusetts. He was a member of the American Medical Association, the American Psychiatric Association, the New England Society of Psychiatry, and a diplomate of the American Board of Psychiatry and Neurology.

Dr. Brennan was a hard worker, spending long hours in his office and his clinic. He loved his work and the people it was his privilege to care for and this was second only to the love he had for his delightful, compact little family. He lived to see his two children well into medical school.

Dr. Brennan was one of the founders of the Guild of Catholic Psychiatrists and at the time of his death he was interested in the movement toward the resolution of any conflicts between scholastic philosophy and modern scientific psychiatry. A few days before his death he was busy with the program for the coming annual meeting of the Guild.

Externally, although he appeared taciturn, he had a lively humor and he read widely. Although on the conservative side in things scientific, he was fully aware of all new things that were going on in his specialty. There were many people quietly dependent upon him and it was said that he had a love for the little people. He interested himself in his patients beyond their medical and psychiatric problems and treated them with kindness and charity.

In the death of Dr. Brennan medicine and psychiatry lost a sincere, hardworking physician who

lived up to all of the ideals of his profession. He is survived by his wife, Mrs. Margaret A. Brennan, a son, Edward N. Brennan, a junior at Yale University School of Medicine, and a daughter, Miss Joan M. Brennan, a student at the Women's Medical College, Philadelphia. He always had in mind something which a grateful patient wrote of him after his death:

"By medicine life may be prolonged,  
yet death  
Will seize the Doctor too."

Francis J. Braceland, M.D.

**Hartford Hospital Has New Director**

Wilmar M. Allen, M.D., for 17 years director of the Hartford Hospital, will become a consultant to the Hospital and will be succeeded by Thomas S. Hamilton, M.D., for the past seven years director of the Newton-Wellesley Hospital in Massachusetts. Dr. Allen will interest himself in research and the overall problems of hospitals as a whole.

Dr. Hamilton was born in Detroit in 1911, attended public schools in that city, Phillips Exeter Academy, Williams College, Harvard Medical School and Wayne University College of Medicine, receiving his medical degree from the latter in 1939. He interned at Harper Hospital in Detroit. After a year of general practice in Wellfleet, Massachusetts, he became assistant director at the Massachusetts General Hospital in Boston.

His work there was interrupted by World War II in which he served for three and a half years in the European theater with the 6th General Hospital in the U. S. Army as executive officer. During the war he rose from the rank of captain to lieutenant colonel. After further service at the Massachusetts General, he became director of the Newton-Wellesley Hospital in 1946.

Dr. Hamilton is New England Regent for the American College of Hospital Administrators and, among other offices, has served as president and trustee of the Massachusetts Hospital Association. He is married and has three children. His father, Dr. Stewart Hamilton, was director of the Harper Hospital in Detroit for 35 years, and Mrs. Hamilton's father, Dr. Frederic Washburn, was director of the Massachusetts General Hospital for 33 years.



## SPECIAL NOTICES

### HARTFORD HOSPITAL PROGRAM OF GUEST SPEAKERS

Saturday Mornings, 11 o'clock  
January 9 to April 3, 1954

January 9

James C. Fox, Jr., M.D., neurologist, Hartford Hospital  
Cerebral Vascular Disease and Its Treatment

January 16

Gerald Klatskin, M.D., associate professor of medicine,  
Yale University School of Medicine  
Portal Hypertension

January 23

John McL. Morris, M.D., associate professor of obstetrics  
and gynecology, Yale University School of Medicine  
Functioning Disorders of the Ovary

January 30

S. J. Thannhauser, M.D., professor emeritus of medicine,  
Tufts College Medical School  
Case presentation

February 6

Donald Matson, M.D., associate professor of neurosur-  
gery, Harvard Medical School  
Hydrocephalus in Childhood

February 13

Jacob Fine, M.D., professor of surgery, Harvard Medical  
School  
The Role of Intestinal Flora in Surgical Disorders  
including Traumatic Shock

February 20

Mr. Leo J. Noonan, State of Connecticut Workmen's  
Compensation Commissioner  
The Young Doctor Looks at Workmen's Compen-  
sation

February 27

Theodore Lidz, M.D., professor of psychiatry, Yale  
University School of Medicine  
Psychotherapeutic Aspects of Diabetes Mellitus

March 6

Gardner Child III, M.D., professor of surgery, Tufts  
College Medical School  
Surgery of Portal Hypertension

March 13

Hattie Alexander, M.D., associate professor of pediatrics,  
Columbia College of Physicians and Surgeons  
The Treatment of Meningitis

March 20

E. Hugh Luckey, M.D., director, Second (Cornell)  
Division, Bellevue  
Management of Refractory Heart Failure

March 27

J. Hartwell Harrison, M.D., associate professor of uro-  
logical surgery, Harvard Medical School  
Adrenal Tumors

April 3

John McK. Mitchell, M.D., dean, University of Penn-  
sylvania School of Medicine  
American Medicine at Mid Century

### HARTFORD MEDICAL SOCIETY

The Program Committee of the Hartford Medical Society  
announces the following series of lectures which will be given  
during the spring of 1954. The fall series of lectures will  
be announced later. All lectures will be held on Mondays  
at 8:30 P. M., in the Hunt Memorial Building, Hartford,  
Connecticut. They are preceded by a clinical conference held  
at one of the local hospitals at 5:00 P. M.

January 18

The Practical Approach to Treatment of Anxiety  
Joseph F. Hughes, M.D., Philadelphia, Pa.

February 1

The Surgical Treatment of Pancreatic Disease  
Richard B. Cattell, M.D., Boston, Massachusetts

February 15

Some Problems Associated With Major Catastrophies  
I. S. Ravdin, M.D., Philadelphia, Pa.

March 1

The Diagnosis and Management of Diseases of the  
Aseptic Meningitis Type  
Theodore E. Woodward, M.D., Baltimore 1, Mary-  
land

March 15

Clinical Disturbances Produced by the Over-function  
and Under-function of the Pituitary Gland  
Edward H. Rynearson, M.D., Rochester, Minnesota

April 5

Angiography  
Israel Steinberg, M.D., New York, N. Y.

April 19

Indications for Surgery in Valvular Heart Disease:  
With Specific Reference to Mitral Stenosis  
Edward F. Bland, M.D., Boston, Massachusetts

# THE HOSPITAL OF ST. RAPHAEL, NEW HAVEN EDUCATION PROGRAM JANUARY 1954

Date Subject

Surgical Conference—Monday 8:00-9:00 A. M.

- 11 Case Presentation
- 18 Neurological Case Presentation
- 25 Mortality and Morbidity

Neurological Conference—Monday 4:00-5:00 P. M.

- 11 Spinal Cord Tumors—Ernest Sachs, M.D.
- 25 Herniated Intervertebral Disc—Ernest Sachs, M.D.

Pediatric Conference—Tuesday 11:30-12:30 A. M.

- 5 Case Presentation
- 12 Case Presentation
- 19 Case Presentation
- 26 Case Presentation

Obstetric and Gynecology Conference—Wednesday 11:30-12:30 A. M.

- 6 Critical Analysis of Primary Cesarean Sections and Mid Forceps Operations in September, October, and November
- 13 Carcinoma of the Cervix
- 20 Statistics
- 27 Pelvic Tumors in Pregnancy

Anesthesia Seminar—Wednesday 3:30-5:00 P. M.

- 6 Journal Club—L. Josephs, M.D.
- 13 Pediatric Anesthesia—L. Trifari, M.D.
- 20 Neurological Complications following Surgery and Anesthesia—J. Pierce, M.D.
- 27 Journal Club—M. Garofalo, M.D.

Urology Conference—Thursday 11:30-12:30 A. M.

- 7 Urinary Tract Anomalies—H. Levin, M.D.
- 14 Testicular Tumors—H. Newman, M.D.
- 21 Hydronephrosis—R. Berneike, M.D.
- 28 X-ray Conference and Case Reports—P. Cavallaro, M.D.

Anesthesia Conference—Thursday 2:30-4:00 P. M.

- 7 Inhalation Anes.—Classification, Principles and Theories
- 14 Inhalation Anes.—Methods—CO<sub>2</sub> Absorption, Endotracheal
- 21 Inhalation Anes.—Stages and Signs of Anesthesia
- 28 Inhalation Anes.—Premedication—Pharmacology of Narcotic Drugs

Medical Conference—Friday 11:30-12:30 A. M.

- 1 New Year
- 8 Case Presentation
- 15 Panel—Acquired Heart Disease II—Drs. L. Joseph, M. Carter, and R. Shapiro
- 22 Cardiac Emergencies—Oscar Roth, M.D.
- 29 Morbidity and Mortality

Pathology Conference—Saturday 11:00-12:00 A. M.

- 9 Clinicopathological Conference
- 16 Surgical and Post Mortem Gross and Micro Pathology Demonstration
- 23 Clinicopathological Conference
- 30 Surgical and Post Mortem Gross and Micro Pathology Demonstration

# CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

January 7

Dr. Robert R. Levin  
Diabetes—Its Management and Complications

January 14

Dr. A. Frederick Serbin  
Shoulder and Arm Pain—Differential Diagnosis

January 21

Dr. Harold Schwartz  
X-ray Conference

January 28

Dr. Stephen H. Sherman  
Psycho-physiological Considerations of Gastro-Intestinal Conditions

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford 4, Connecticut (Main Conference Room).

## BRIDGEPORT HOSPITAL MEDICAL EDUCATION PROGRAM (1953-1954)

### Daily

9:30 A. M. Pediatric Ward Rounds, Children's Ward  
10:00 A. M. Medical Ward Rounds, West Wards  
1:00 P. M. Surgical Ward Rounds, East Ward and Perry "C"

### Weekly

Monday 4:00 P. M.

Radiology lecture or demonstration, staff conference room

Wednesday 11:00 A. M.

Pediatric Staff Rounds, children's ward

11:00 A. M.

Clinico-pathological and Chest Conferences, alternately, staff conference room

Thursday 11:00 A. M.

Medical Staff Rounds, II west classroom

Friday 9:30 A. M.

Obstetric Staff Rounds, II west classroom

11:00 A. M.

Tumor Clinic, Perry roof

4:15 P. M.

Surgical Case Study, operating suite lounge

Saturday 10:30 A. M.

Surgical Staff Rounds, operating suite lounge



**Monthly**

Third Friday 8:30 P. M.

Medical Audit (death review), auditorium

Last Thursday 4:00 P. M.

Gross Neuropathology (brain sectioning), autopsy room

In the near future a series of lectures will be given on various aspects of Human Tuberculosis by staff members of the Laurel Heights Sanatorium.

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### POSTGRADUATE COURSE IN DIABETES AND BASIC METABOLIC PROBLEMS

January 18, 19 and 20, 1954 at Rochester, Minnesota

The second Postgraduate Course in Diabetes and Basic Metabolic Problems to be conducted by the American Diabetes Association will be offered under the directorship of Edward H. Rynearson, M.D., and Randall G. Sprague, M.D., consulting physicians, Section of Medicine, Mayo Clinic; Professors of Medicine, Mayo Foundation, Graduate School, University of Minnesota, Rochester, Minnesota. The course will be held at the Mayo Clinic and Mayo Foundation, Rochester, Minnesota. There will be a total of over thirty-five lectures and round table discussions.

The course is open to non member physicians as well as members of the American Diabetes Association, but the number of registrants will be limited to 125. Fees are \$40 to members, \$75 to non members. Details of the three-day program and registration and hotel information may be obtained from J. Richard Connelly, executive director, American Diabetes Association, 11 West 42nd Street, New York 36, N. Y.

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### FIFTIETH ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE

Monday and Tuesday, February 8-9, 1954, Red Lacquer Room, Palmer House, Chicago.

The Annual Congress on Medical Education and Licensure is conducted under the auspices of the Council on Medical Education and Hospitals of the American Medical Association and the Federation of State Medical Boards of the United States.

In addition, the following open meeting will be held at the Palmer House immediately preceding the Annual Congress on Medical Education and Licensure: Sunday, February 7, 9:00 A. M. - 12:30 P. M. Open meeting of the Advisory Board for Medical Specialties.

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### YALE UNIVERSITY DEPARTMENT OF PUBLIC HEALTH

New Haven, Connecticut

#### Medical Jurisprudence 1953-1954 — Special Sessions

Arranged by Department of Public Health and School of Law, Yale University. Especially for students of medicine, and of law, and for house officers. Thursday 4:00 P. M., Brady auditorium.

December 10

Sidney Shindell, M.D., LL.B.

Introduction to the Law

December 17

Sidney Shindell, M.D., LL.B.

The Physician-Patient Relationship

January 7

Richard Ford, M.D.

Special Medical-Legal Problems

January 14

Richard Ford, M.D.

Malpractice

January 21

Sidney Shindell, M.D., LL.B.

The Government and Medical Practice

January 28

Louis Sachs, LL.B.

Workmen's Compensation

February 4

An Obstetrician and a Lawyer

Legal Aspects of Planned Parenthood

February 11

Fowler Harper, LL.B.

Introduction to the Law of Torts

February 18

George Dession, LL.B.

The Physician in Court

Questions may be addressed to Ira V. Hiscock, professor of Public Health, 310 Cedar Street. LOcust 2-1161, Extensions 435 and 478.

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### ALCOHOLICS ANONYMOUS TO MEET

Fifth Annual International Group of Doctors in Alcoholics Anonymous, Mayflower Hotel, Akron, Ohio, May 14, 15 and 16, 1954. For information and reservations address: Doctors, Mayflower Hotel, Akron, Ohio.

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### AMERICAN COLLEGE OF SURGEONS

The sectional meeting of the American College of Surgeons will be held in Montreal, Canada at the Mount Royal Hotel from March 31, 1954 to April 2, 1954.

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### YALE PSYCHIATRIC INSTITUTE

333 Cedar Street

New Haven 11, Connecticut

The Psychiatric Institute of Yale University is a non profit organization and every effort has been made to keep rates at the lowest level compatible with adequate patient care. In

order to assist the person responsible for the patient's financial obligations a brief outline of the Institute's services and charges is given below. This summary should be considered only as a general guide; each case is discussed individually at the time of the patient's admission.

ADMISSION AND GENERAL CARE

The basic daily rate covering room, board and general nursing care is \$20, or \$140 per week, payable in advance. When it is necessary to permit hospitalization for many months some adjustment of this rate may be made, at the discretion of the Administrator. At the time of admission an added \$50 payment covers the cost of routine x-rays, laboratory and psychological tests and other necessary preliminary expenses of a similar nature.

PROFESSIONAL SERVICES

In addition to the basic rate, there is an established charge for various professional services of \$200 a month. However, as this is a University institute, the professional fee may, under special circumstances, be adjustable.

SPECIAL SERVICES

Regular nursing care is provided under the basic rate, a special nursing charge being made only in the unusual circumstance that the patient needs a private duty nurse. Medical consultation, when needed, is also provided without extra charge; but dental or surgical care, transportation by ambulance, etc., are covered by additional charges.

SPECIAL DAY OR NIGHT PLAN

Recovering patients for whom full-time employment is considered desirable and others who may benefit from the Institute's day program but who can manage staying at home over night can be accommodated. The basic fee for either of these programs is \$13 a day.

DOCUMENTS REQUIRING SIGNATURE

When the admission to the Institute is made on a voluntary basis, the patient is asked to sign a statement of voluntary commitment. At the time of admission the person assuming financial responsibility is asked to sign a certificate acknowledging agreement to pay all bills which may become due in connection with the care and treatment of the patient.

DISCHARGE PROCEDURES

All outstanding expenses incurred by the patient must be cleared with the business office at or prior to the time of discharge.

MARRIAGE CONSULTATION SERVICE

A Marriage Consultation Service has recently been started as a branch of the Department of Psychiatry Yale University, in order to provide counsel for persons with the specific complaint of marital problems. This service offers diagnostic consultation, psychotherapy and appropriate referral for further treatment where indicated. Fees for this service are set in accord with the patient's ability to pay.

The Service is located in the Institute of Human Relations and is under the direction of Dr. Stanley A. Leavy, assistant

True copy of the requisition for X-Ray  
Literatures published in the American  
X-Ray Technician dated March, 1953

Books For India

A letter has been received from a Doctor in a Mission Hospital in India, requesting good radiological books, Journals et cetera. The doctor states that very few books are available at the hospital. The few books that are for sale are very expensive and the hospital is unable to pay for them. This institution is a charitable one and their funds are very limited.

The *X-Ray Technician* will be sent to the hospital regularly with compliments of the ASXT.

Members of the ASXT are requested to send books on radiography and medicine, that are still up to date, but are not being used. Old copies of medical journals will be acceptable.

Address all material to Dr. T. K. Thomas, Medical Superintendent, St. George's Mission Hospital, Punalur P. O., Travancore, South India.

clinical professor of psychiatry. Associated with him are members of the resident and clinical staffs and Mrs. Miriam C. Harper, psychiatric social worker.

Calls for appointments and further information may be made to Mrs. Reidy, secretary, at LOcust 2-1161, Extension 578.

NEWS

from County Associations

Fairfield

The annual meeting of the Bridgeport Medical Association was held in the auditorium of St. Vincent's Hospital on December 1. The Nominating Committee consisting of George A. Buckhout, Joseph J. Esposito and Michael A. Dean presented a slate of officers for the year 1954 as follows: President, John F. Nolan; President-Elect, Edward P. Kemp; Vice-President, Edwin R. Connors; Secre-



tary, Albert Levenson; Treasurer, Joseph G. Hennessy. The newly elected officers will be installed at the annual banquet to be held on January 12. The scientific portion of the meeting consisted of a paper given by Paul B. Beeson, Ensign professor of medicine at Yale University School of Medicine and chief of the medical service, University Division at the Grace-New Haven Community Hospital on "Fever of Obscure Origin."

Alexander J. Tuttle, medical director of Hillside Hospital, has resigned his position to become affiliated with the Department of Health for the State of Connecticut. Dr. Tuttle will assume his State duties about the first of February.

### Hartford

A four page folder telling patients about physical examinations and how to get a family doctor has been approved by the Public Relations Committee of the Hartford County Medical Association. Listing the numbers of times a patient should see a doctor, and the physical examination he should get, this pamphlet will be distributed through radio and TV stations.

"Operation Herbert," a new 30 minute film prepared especially for TV by the AMA, was released last month by HCMA over WKNB-TV. The film explains in a humorous fashion that it costs less for medical and hospital treatment now than it did in 1937.

One hundred thirty-seven members of HCMA attended the semi-annual meeting in Newington. Seventeen guests, including George H. Gildersleeve, president of the State Society, and H. M. Marvin, president-elect of the State Society, were also present. Twelve new members out of thirteen were on hand.

The dean of East Hartford's medical men, Harry J. Onderdonk, has retired from medical practice at the age of 81 after 56 years of practice. Dr. Onderdonk, who served up to the first of November as the East Hartford medical examiner, received his medical degree at New York University in 1897. Born in Albion, New York, Dr. Onderdonk came to Connecticut in 1898.

Amos E. Friend, Stanley B. Weld, and Egbert A. Andrews and the executive secretary, Joseph L. Gordon, attended the AMA's Committee on Fed-

eral Medical Services' meeting in New York on November 13.

In October, in cooperation with the City of Hartford Health Department, HCMA exhibited a series of panels describing the work of the World Health Organization. This was part of a display commemorating UN Week.

Joseph F. Jenovese of Hartford died at the Hartford Hospital on November 24, 1953 after a long illness. Dr. Jenovese was an assistant in medicine on the staff of the Hartford Hospital. He was 46 years old.

The newly elected officers of the medical and surgical staff of St. Francis Hospital, Hartford, elected at the annual meeting on December 10 are: President, Walter L. Hogan; President-Elect, Richard C. Buckley; Secretary, John E. Franco; Treasurer, Timothy E. Curran; Assistant Secretary, James S. Missett. Members of the Executive Committee are James J. Hennessy, Donald J. McCrann, Maurice F. O'Connell, the president, president-elect and secretary.

### Middlesex

On October 22, 1953 the new pathology laboratory at the Middlesex Memorial Hospital was dedicated to Jessie W. Fisher at an elaborate ceremony. Dr. Fisher was the founder of the original laboratory in 1916 and was the pathologist of the hospital for over 20 years, until her retirement.

She also took part in many other activities both medical and non medical. She was in France on a medico-military assignment during World War I. She established the city health department laboratory and was instrumental in starting the hospital tumor clinic. She served on many of the committees of the State Society. On the non medical side she was a member of the Portland School Board and a trustee of the Connecticut State Hospital.

Norman Gardner attended the interim session of the AMA at St. Louis early in December.

Julius H. Grower was recently made president-elect of the Connecticut branch of the American Academy of General Practitioners.

Christie McLeod attended the annual meeting of the College of American Pathologists held in Chicago in the fall.

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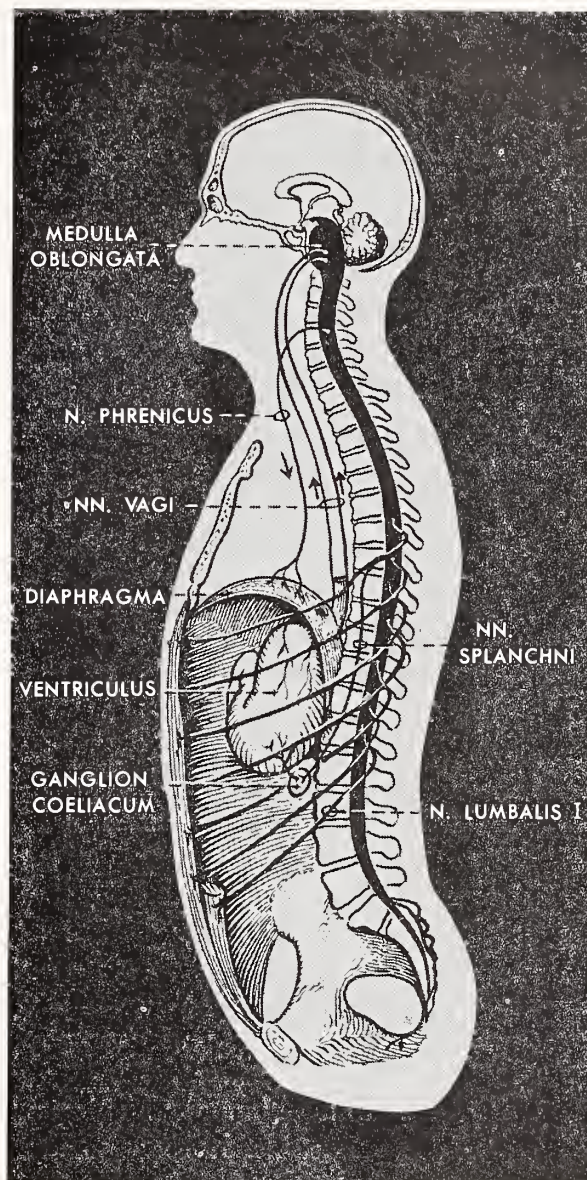
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1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey 50:53 (Feb.) 1953.

2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus*→*nodose ganglion*→*solitary tract*→*spinal cord*→*cervical, thoracic and lumbar nerves* to *diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature*. (After Krieg, W. J. S.: *Functional Neuroanatomy*, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)



## New London

Members of New London County Medical Association were guests of the medical officers of the U. S. Submarine Base at the regular monthly meeting which was held on Thursday, December 3, 1953 at the U. S. Submarine Base. The speaker was Alexander Marble, clinical associate in medicine, Harvard Medical School and physician at New England Deaconess Hospital, Boston, Massachusetts. His subject was "Diabetes."

The last dinner lecture meeting of the Lawrence and Memorial Hospital was held Thursday, November 19, 1953. The speaker was Harry Miller, surgeon, New England Center Hospital, and assistant professor of surgery, Tufts College Medical School. His subject was "Tumors of the Head and Neck."

The William W. Backus Hospital has received a notification from the Joint Commission on Accreditation of Hospitals that it is now fully accredited.

At a staff meeting held at the Backus Hospital on

December 10, 1953, Ethan Allen Brown of Boston, Massachusetts, spoke on "Recognition of Phenomena in the Field of Allergy."

The Board of Trustees of the Lawrence and Memorial Hospital New London announced the new staff appointment of the following doctors to be effective January 1, 1954:

Joseph T. Murray, Gynecology and Obstetrics; William J. Murray, Jr., Medicine; Louis P. Saxe, Medicine (neurology and psychiatry).

New London Chapter of the Connecticut Heart Association presented a lecture on December 10, 1953 at the Lawrence and Memorial Hospital. The speaker was Louis Bishop. His subject: "The Complications of Myocardial Infarction."

Joseph T. Murray was discharged from the U. S. Navy on December 1, 1953 and has reopened his office at 342 Montauk Avenue in association with Eric Blank and F. W. Goodrich, Jr. for the practice of obstetrics and gynecology.

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## NEW BOOKS IN REVIEW

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*THE YEAR BOOK OF MEDICINE (1953-1954 Year Book Series). Edited by Paul B. Beeson, M.D., Carl Muschenheim, M.D., William B. Castle, M.D., Tinsley R. Harrison, M.D., George B. Eusterman, M.D., and Robert H. Williams, M.D. Chicago: The Year Book Publishers, Inc. 1953. 736 pp. \$6.*

Reviewed by WILLIAM G. LEEDS

The editors have divided this book into six sections: infections, chest, blood and blood forming organs, cardiovascular-renal disease, the digestive system, and metabolism. They present brief summaries, with valuable comments, of the more important articles in the world's medical literature published between May, 1952, and May, 1953. The section on infections stresses articles concerned with bacterial resistance, the changing nature of bacterial infections, and newer antibiotics, notably erythromycin. An excellent summary of current knowledge of Cocksackie virus is presented. One especially interesting phase of this section is concerned with the incidence and potential significance of chronic biologic false positive serologic tests for syphilis. The importance of this finding resulted from the work of Nelson and Mayer, who discovered the treponema pallidum immobilization test. The editorial comments and opinions frequently add to or explain the material summarized.

Revealing his primary interest, Dr. Carl Muschenheim devotes more than a quarter of the section on chest disease to tuberculosis. The chemotherapy of this disease, especially

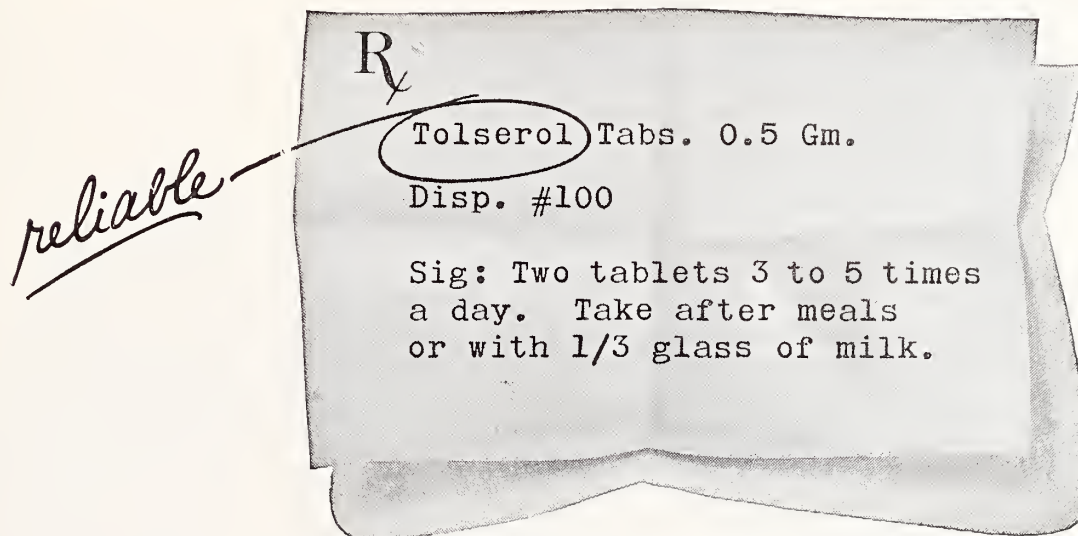
with regard to isoniazid in miliary and meningeal tuberculosis, receives particular attention. Many long explanatory notes accompany this portion of the work, and the editor's excellent comments greatly enhance the value of the articles. The remainder summarizes current knowledge of lung anatomy, pulmonary physiology, the pneumoconioses, tumors, and miscellaneous chest diseases. Such articles have practical value for the clinician.

Dr. William B. Castle edited the largest subdivision which deals with the numerous advances in the field of hematology. Outstanding are the works concerned with the immunologic etiology of many blood dyscrasias, the ever growing chemotherapy of leukemia, lymphoma, and polycythemia, together with several papers on the complex problem of the clotting mechanism and its defects. The careful editing of the voluminous literature in this branch of internal medicine plus the myriads of informative notes should make this subject interesting to both general practitioner and internist.

Cardiovascular-renal diseases are treated in one group subdivided into the multiple facets of this broad clinical field. These include hypertension, congenital heart disease, cardiac surgery, electrocardiography, peripheral vascular disease, and renal disease. Of interest are the summaries covering refractory heart failure, the use of carbonic anhydrase inhibitor as a diuretic, isopropyl nor-epinephrine in Stokes-Adams syndrome, and the clinical indications for commissurotomy in mitral stenosis.

A great deal of basic work on the physiology of the gastrointestinal tract, especially in its relation to peptic ulcer and diseases of the esophagus is reported in the gastroenterology literature. Dr. Eusterman deals extensively with the evaluation of the numerous anticholinergic drugs in the

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treatment of ulcer. Recent developments in the management of chronic liver disease, the pathology and treatment of the sprue syndrome and ulcerative colitis are adequately presented. Malignant tumors receive relatively little mention.

The metabolism section contains papers on the adrenocorticosteroids, adrenocortical hyperfunction and some of the newer developments in the pathophysiology of thyroid disorders and their control. In regard to the latter, there are good references to radioactive iodine, methimazole and potassium perchlorate in hyperthyroidism and tri-iodothyroxine's relationship to the active principle of dessicated thyroid extract. Emphasis is given nor-epinephrine in the treatment of hypotensive crises of various causes. Diabetes and its many ramifications including insulin mechanisms of action, control of degenerative changes, and electrolyte problems in diabetic acidosis receives wide coverage with some controversial views discussed.

The Year Book has both a subject and author index which are adequate. The former contains sufficient cross indexing to make it useful as a starting point for locating material on specific topics. Every summary in the volume is referenced by foot-notes, so that the interested reader may consult the original papers where indicated. Since each department of the Year Book is edited by an expert in the field, their sound comments guide the reader's interpretations and place in proper perspective many articles on recent discoveries. The editors do not hesitate to express opinions and offer suggestions, and many of these opinions are documented by their own extensive literature, a product of lifelong experience with their subject. This volume should be of value and fill a specific need of the busy practitioner by making it possible for him to keep abreast of progress in medicine with relative ease.

*ANTIBIOTICS.* (Second Edition.) By Robertson Pratt, PH.D., and Jean Dufrenoy, D.Sc. Philadelphia: J. B. Lippincott Company. 1953. 87 illustrations, 398 pp. \$7.50.

Reviewed by WILLEM F. VON ECK

This book is an introduction into the science of antibiotics. It covers virtually all its aspects in a well balanced form. It is not meant to be a practical guide for antibiotic treatment, in fact, clinical discussions are few and clinical indications for treatment are mostly somewhat cursory. But any physician who wants to read a fascinating story of what antibiotics are and what their great significance is for our society should read this book. They will be amused to see that the growth curves for a green alga in days and the synthetic dye industry in years are identical but at the same time appreciate the similarities between a human society and a society of micro-organisms. Or they will be dazed at the view of the nearly 300 different tabulated antibiotics and ponder over the amount of research work hidden beyond these simple data. The industrial production methods and screening techniques are briefly and clearly discussed. The greater part of the text is taken in by the applied aspects. These include first an ample discussion of the clinically used antibiotics, individually and as mixed antibiotic therapy, then in separate chapters, the use of antibiotics in dentistry and oral surgery. In agriculture antibiotics are also important, therapeutically in animal infections and as growth stimulants for animals under certain conditions.

Ample discussions are given to the problem of the emergence of resistant strains of micro-organisms and to the biochemical processes which are now known to be influenced by some antibiotics as well in the bacteria as in tissue cells. The social and economic aspects are also discussed and if the reader needs quantitative figures to be impressed he certainly should be so on learning that our pharmaceutical industries now produce annually 600 tons of the well known antibiotics.

A few minor criticisms may follow. In mentioning the groupwork necessary to develop antibiotics, the physicians are left out (page 7); they were, however, in my opinion indispensable. Also, many toxicities of different antibiotics have been discovered only by clinical observation; and clinical experience has led to prevention of some of them (streptomycin). Most physicians will disagree with the discussion of the use of broad-spectrum antibiotics in "septicemia of undetermined origin" (p. 209). Prophylactic use of oral penicillin in rheumatism might have alleviated the statement on the use of antibiotics as prophylactic agents. Combination of penicillin with antihistamines could have been mentioned in the remarks on allergic reactions. The literature is quoted rather unsystematically, either in the text or in footnotes, and, although it is obviously impossible to be complete in quotations, one misses, for instance, the literature on the joint use of cortisone and chloramphenicol in typhoid fever (p. 201).

The text is well written and clear. It is profusely illustrated with graphs and diagrams which are of good quality. Besides the literature quoted in the text, suggested articles up to and including the first half of 1953 are mentioned at the end of each chapter to introduce the reader to the corresponding literature.

This book is recommended to any physician who wants to look behind the curtain of clinical application of antibiotics.

*AFFECTIVE DISORDERS: PSYCHOANALYTIC CONTRIBUTIONS TO THEIR STUDY.* Edited by Phyllis Greenacre, M.D. New York: International Universities Press, Inc. 1953. 212 pp. \$3.

Reviewed by HUGH J. CAVEN

This is a collection of papers on various psychoanalytic aspects of depression and mania. Only one of the five deals with mania and that is about the proper odds in view of what is known about these conditions respectively. Dr. Phyllis Greenacre, the editor, in a tidy foreword runs lightly and instructively over the problem. Toward the end she even gets a touch of nobility into it. I wish she had written one of the papers, the longest one.

In the first one, Edward Bibring presents the thesis that depression is the result of tensions within the ego and not of conflicts among ego, id impulses and superego. The feeling of having failed to reach certain personal goals combined with the retention of the aspiration toward such goals brings about a serious fall of self esteem, feelings of inadequacy and unworthiness. This is "neurotic" depression. In psychotic depression he feels that the basic mechanism consists of aggressive id impulses directed against an orally incorporated (very primitive) object.



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Edith Jacobson in the next paper considers the nuclear element in depression to be feelings in the ego of helplessness, weakness and loss. Besides all this, there's a sort of bonus—a tightly packed analytic blueprint of the psychotic process. "Regressive fragmentation" she calls it.

Elizabeth Zetzel's contribution is primarily a critique of Melanie Klein's concept of the "depressive position." According to this the origins of depression lie in the ambivalent feelings of love and hate the infant is believed to have for its mother or, in the parlance, the love object.

There is another paper on depression that shows how anorexia can serve as a depressive equivalent. For the most part it is just an elaborate case history heavily laced with analytic comment.

The only article on mania opens with a discussion of the usual explanations of the inner workings of this condition and finds them all inadequate. The author then proceeds to an explanation of his own—also inadequate, as he points out.

Inadequately, here it is. Mania is considered as an attempt at restitution by the ego. This the ego achieves by regressing from the reality principle to the pleasure principle temporarily. Insulated by a constant supply of pleasure, the ego is able to pull itself together. Incidentally, the manic's flight of ideas is very ingeniously explained as a urethral displacement mechanism.

All of these concepts are integral parts of complex, skillfully woven webs of ideas. Jerked out of context, they lose something—possibly their meaning. So, to get it straight, you will just have to read the book.

**LIVING WITH A DISABILITY—AT HOME—AT WORK—AT PLAY.** By Howard A. Rusk, M.D., and Eugene J. Taylor. New York: The Blakiston Company, New York. 1953. 330 pp. \$3.50.

Reviewed by JOHN C. ALLEN

This book is a very real contribution to the field of Physical Medicine and Rehabilitation and to medicine generally because of the extensive presentation of concrete methods of approach to various types of disabilities. It is unique in its presentation in that it is largely a pictorial description of equipment and methods used to handle both major and minor disabilities in all activities of self care as well as ambulation and elevation. It includes floor plans for bath rooms and kitchens with adaptive equipment for personal use as well as household activities. Further, it includes names and addresses for procurement purposes of all pictured equipment. These are very clearly labeled and the addresses are in a special appendix at the end of the book. This has been done to a limited degree by the same authors in serial fashion during the past four years in paper covered pamphlet form to the great advantage of people in physical medicine and in rehabilitation work throughout the country. This book, however, condenses the previous presentations and puts it in permanent form to the very great convenience of anyone interested and is a book which could very logically be of value to the families of such patients since the presentation is simple and not technical but extremely practical. It is highly recommended for all physicians and other personnel

working with this type of patient and should be included in all medical libraries.

**MAY'S MANUAL OF DISEASES OF THE EYE.** Revised and edited by Charles C. Perera, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Attending Ophthalmologist, Presbyterian Hospital, New York. Baltimore: Williams & Wilkins Company. 1953. 512 pp. \$6.

Reviewed by CLEMENT C. CLARKE

This hardy perennial has proved its value and popularity in twenty-one American editions, twelve Spanish translations, eleven British, seven Italian, six French editions, and also in Japanese, Chinese, German, Portuguese, Dutch and Urdu (India).

In the preface to the first edition, dated August 1900, Charles H. May expressed his intention by saying "that this book is not recommended as a substitute for larger works, but as a means of supplying a foundation to which further knowledge may be added by reference to more extensive and comprehensive text books." He makes a point of describing in relative detail the common conditions which the medical student and general practitioner encounter in their daily activities. However, he does not ignore the more unusual conditions, but he reduces their description to a definition which provides a basis for further study. There is no one reason for the continuing popularity of such a book as this: undoubtedly the convenient size, the vivid language, the numerous illustrations all play a role.

The present editor, Charles Perera, has been associated with Dr. May since the mid 30's in preparing all editions since the fourteenth edition of 1934.

This present twenty-first edition and the previous twentieth have been Dr. Perera's entire responsibility as Dr. May died a few years ago. Dr. Perera has continued the same format; his corrections and omissions in editing have been by way of modernizing the information, rather than in changing the character of the presentation. He has improved the illustrations by substituting thirty-five new color drawings in this edition. He has retained some of the old fashioned black and white cuts, which have been in the book since its early days. This is a benefit rather than a detraction since it adds an historical flavor to the book without sacrificing the informative content. May's *Manual on the Diseases of the Eye* remains as it has always been, one of the top student texts.

**THE NURSING MOTHER.** By Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P., Licentiate American Board of Pediatrics. New York: Prentice-Hall, Inc. 1953. 204 pp. \$2.95.

Reviewed by STANLEY B. WELD

The author claims that this is the first book written in America devoted exclusively to breast feeding. Although it is written primarily for the antepartum or postpartum woman, it contains much which will bear careful reading by obstetricians and pediatricians alike. Dr. Richardson's thesis rests on the belief that breast feeding gives a baby not only



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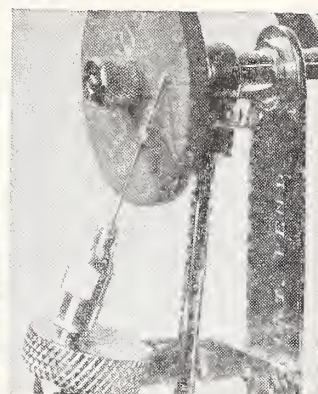
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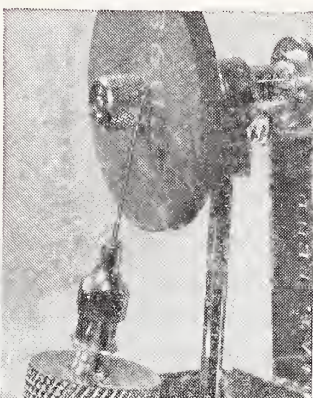
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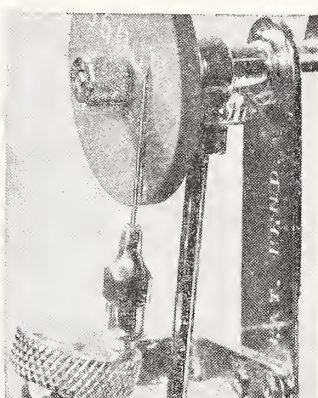
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better chances for physical health but contributes certain undisputed emotional advantages which bottle feeding cannot supply. In addition, a team is developed—father, mother and child—all interested in creating and maintaining the happy home.

The author quotes Dr. W. P. Nicholson, Jr. of Atlanta, Georgia who states that experimental and clinical evidence have proven that failure of the breasts to properly perform their normal function is one of the commonest causes of cancer of the breast. Statistics from Nassau County, Long Island, are referred to where infants breast fed for nine months showed a lower morbidity rate than those nursed less than nine months. This argument has recently been refuted by figures from England where the incidence of disease in bottle fed and breast fed infants showed no appreciable difference. And then, too, we cannot help raising the question, "How many nursing mothers carry on breast feeding for nine months?"

This is a very complete book. The author has presented all the arguments for breast feeding and does not hesitate to advise against it if the mother is not in complete sympathy with the program. The care of the breasts is outlined in detail and there is a discussion of the anatomy and physiology of the breasts, the place of the husband in the care of the infant, natural childbirth, rooming-in, dietary additions for the infant, and the advised method of weaning when such a procedure becomes necessary. About every question a woman could ask having any bearing on breast feeding is raised by the author and answered in detail. With the returning interest in breast feeding this book should be welcomed by many.

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### SUMMARY

Accidents in the home and the immediate surroundings are a major cause of death and disability in the United States. Studies of hundreds of accidents in areas of New Haven, of Kansas and of Nassau County, New York, reveal that falls, fire and suffocation or strangulation are leading specific causes, and that children and the aged persons suffer most.

Poisonings and numerous other accidents are common among children under five years of age. Until parents, and others who care for these children, understand and carry out more fully the elementary precautions to be taken to make a home safe for a small child, the number of accidents in this age group will continue to be large.

In the United States in 1952 there were two million persons injured while at work and 15,000 more killed. In comparison, 4,300,000 persons were injured in home accidents, and 29,000 killed! Accidents of all types are the leading cause of death among persons of 1 to 35 years of age.

Considerable preventable disability resulting from home accidents can be brought to the attention of medical students and house officers. Besides hospitals, medical and nursing schools, there is opportunity for health departments, schools, medical and other health organizations and safety councils to assume more active roles in cooperative community programs in efforts to reduce home accidents and their resulting expenses, unnecessary incapacity, and unhappiness.

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### A QUICK VIEW

When primitive man moved from the doubtful security of the jungles and forests into a convenient cave, he added a new hazard to those already besetting him. He replaced the dangers from the elements and roaming beasts with the dangers of home accidents. Now that the modern home has evolved into an elaborate structure, with complicated apparatus, fire and gas, hard floors, steep stairs and other traps for the unwary, the dangers of the primeval jungle fade while the cave-dweller's home appears as a simple haven, safe and secure.

Man has exchanged tripping over a carelessly flung sabre-toothed tiger skin, landing on a soft grass-strewn floor, for the rigors of negotiating polished floors of unyielding material, dotted with strategically placed scatter rugs; a blessed state of unwashedness for the trap of the slippery bathtub, and the skidding piece of soap; the clay pot set firmly in the firepit for the gleaming electric range, with a hot burner showing no indication of its hidden danger. Man, and his children, are often cooped up in boxes of tricks ready to cause death and destruction to those without care and knowledge. The child who pulls a pan of boiling water over himself when his mother's back is turned, and the old woman who falls to death after tripping on the top tread of a badly lighted or slippery staircase are both victims of man's civilization.

Within recent years we have seen the conquest of those scourges of mankind, the communicable diseases, with dramatic reduction of deaths at all ages. Even tuberculosis, the White Plague, is being slowly brought under control. Some of the dangers of the home are being reduced. With the passing of the open fire, and of the naked candle flame, one



hears fewer stories of women and children whose voluminous dresses of highly inflammable material became their own funeral pyres. With the slow rise in the level of general education, there is more knowledge of safe child rearing practices. May the future see less of such an incident as when a young woman came into the emergency department of a large city hospital, placed a bundle on the desk, and said she had "boiled her baby!" She had placed the baby's bath, full of water, on the gas stove, lit the flame under it, placed the baby in the bath, and "just popped out for a moment." When she came back the baby was dead. This seems to be an extreme case; but almost daily one can hear tales of mothers giving children sharp instruments to play with, leaving pills, cleaning fluids, acids, weed killer and so on, in places easily accessible to small and curious fingers, and who seem surprised and indignant when the child is hurt or poisoned.

In 1952 some 96,000 deaths in the United States were due to accidental causes, while 100 times as many persons were injured.<sup>1</sup> Two million persons were injured while at work and 15,000 more were killed. That 29,000 persons were killed and 4,300,000 injured in home accidents last year may be a surprise. They were once alive boys and girls, men and women, infants and grandparents, all with names and faces, families and friends. All accidents are expensive. Accidents of all types, furthermore, are the leading cause of death among persons of 1 to 35 years of age.

#### GRIM FACTS AND RELATIONSHIPS

Results from two localized studies of nearly a thousand fatal home accidents occurring in Nassau County, New York, and in the State of Kansas revealed the following:<sup>2</sup>

1. Three out of five accidental home deaths resulted from falls; one in seven was from fire, and one in ten from suffocation or strangulation.
2. Children and the aged suffered most; in four out of five cases the victim was under five or over sixty-five.
3. More females than males died, in a proportion of three to two. Seven out of ten female deaths were

due to falls as compared with four out of ten for males.

4. Three-quarters of these home deaths occurred inside the house, the remainder in the yard, or on the porch, or nearby.

5. More than half of the deaths followed fractures, especially common for the aged.

#### INJURIES

Information about fatal home accidents can be obtained by following up death certificates, but studies of non fatal home accidents are more difficult. What little is available comes from hospital and nursing records and through local efforts, sometimes with the cooperation of local schools, Red Cross chapters and Safety Councils. There is lack of uniformity of records; figures showing classification, coverage, and methods of treatment vary from place to place and with local energy and enthusiasm. Too often missing is an indication of the severity of injury and the degree of disability.

#### NEW HAVEN EXPERIENCE

In the 6 years of 1946-1951 there were 294 deaths from accidents in the New Haven area. Information concerning 54 of the 55 deaths in 1951, as observed by the New Haven Safety Council, is shown in Table 1.

TABLE 1  
HOME ACCIDENT DEATHS BY MONTH, GREATER NEW HAVEN,  
1951

MONTH	NO. DEATHS IN MONTH	NO. DEATHS BY MONTH OF INJURY	DEATHS BY MONTH PER CENT OF INJURY
January	4	1	2.0
February	4	6	11.5
March	4	3	5.8
April	4	4	7.8
May	2	2	4.0
June	4	4	7.8
July	5	6	11.5
August	0	1	2.0
September	1	0	0.0
October	7	11	19.5
November	8	7	13.5
December	11	7	13.5
	54	52*	100.00

\*Two injuries occurred the previous year

<sup>1</sup>Accident Facts, 1953 Edition, National Safety Council, Chicago.

<sup>2</sup>National Safety Council, Analysis of Fatal Home Accidents, (Chicago: National Safety Council, Statistical Division, 1948) p. 29.

Nearly two-thirds of these accidents occurred during the period of October through March, when there was greater confinement in the home. Men and

women suffered equally. There was a preponderance of persons over 65 years of age; and almost two-thirds of the deaths were caused by falls (on stairs, from windows, tripping over rugs, etc.). The burns (10.9 per cent) included falling against a stove, fire from smoking in bed, burning leaves. A small scale, local "pilot" survey was made of non fatal home accidents, including only those home accidents which were seen in the emergency room of the Grace-New Haven Community Hospital throughout the month of July 1952.<sup>3</sup> The total number of home accidents which passed through the emergency room of the New Haven Division of the Grace-New Haven Hospital from midnight, June 30, 1952, to midnight, July 31, 1952 was 238. One death was recorded (patient was brought in dead). There were seven admissions, while 106 other accidents were considered disabling for more than 24 hours.

TABLE 2  
HOME ACCIDENTS IN THE EMERGENCY ROOM  
JULY 1952

	NUMBER	PERCENTAGE
Deaths.....	1) Total	0.4) Total per cent
Admissions.....	7) disabling	2.9) disabling
Disabled.....	106) 114	44.5) 47.9
Not disabled.....	124	52.1
Total.....	238	100.0

The total number of home accidents treated in the emergency room is large, considering that this must represent only a small part of those occurring in New Haven. Perhaps three thousand home accidents in a year pass through the emergency room at only one of the general hospitals in the area. The estimated ratio of non fatal home accidents seems to vary according to source, but is usually estimated at 150 injuries to each death.<sup>4</sup> Apparently New Haven suffers from at least the average number of home accidents. More than half the home accidents treated were not disabling. It is doubtful if only the most serious injuries find their way to emergency treatment at the hospital, yet there is no way of telling how many trivial accidents were not hospital treated.

<sup>3</sup>Admissions from the emergency room were included in the study, but admissions from outside, other than directly from the emergency room, were omitted. This was done in the belief that outside admissions should be included only if home accident cases seen in doctors' offices also could be included in the study.

<sup>4</sup>Accident Facts, 1950 edition (Chicago: National Safety Council), p. 81.

There appears to be a time pattern running through each week. The month of July was complicated by the holiday, Fourth of July, which fell on a Friday; but each week showed an increase in accidents treated on Friday and Saturday (average of 9 to 10 as compared with 5 to 8) which was only slightly more noticeable over the weekend of the holiday. The school children were on holiday during July and so at home as much during this month as any other month during the year. It would be interesting to discover during a school month if there is as marked midweek drop. A full year survey is necessary before definite conclusions can be reached.

In all but twenty cases it was possible to obtain some idea of the time of day at which the accident happened. Only a few accidents occur between twelve midnight and 8 A. M. The only one which happened between 3 A. M. and 8 A. M. was the case of a small girl who stepped on a pin which became buried in her foot. A steady rise through the morning suggests increased activity in the home, while a noticeable jump between 11 A. M. and noon probably represents a shift to the kitchen to prepare lunch for the children. A lull sets in after lunch, perhaps because the small children are resting. A jump between 4 and 5 P. M. is more difficult to explain. Another rise may represent a last play in the yard, until 9 P. M., when probably most of the young children are in bed. Apparently one is fairly safe after the hazards of bedtime. A variation has been found in industrial accidents, where there is a rise to a peak between 10-11 A. M., and again between 3-4 P. M.<sup>5</sup> Are the similarities between home and industry due to common factors or unrelated? More females than males are the victims of fatal home accidents in the United States. But males of all ages suffered more non fatal home accidents than females, although there are more females than males in the general population. This is surprising. After all, if woman's place is in the home one would expect her to run a greater hazard there than the male. However, the death toll of home accidents rises with age, and women may be outliving men only to become victims of home accidents.

Considering the total patients in each age group, the largest group are under five years of age, with the next largest in the five to nine group. This is the reverse of the trend found when fatal home accidents were studied. There the overall tendency was

<sup>5</sup>Accident Facts, 1950 edition, op. cit., p. 31.



for the deaths to increase with age, whereas the relative number of injuries reported tends to decrease with age. The results are grouped below to represent, roughly, preschool, school age, productive life, and old age.

TABLE 3  
HOME ACCIDENTS IN THE EMERGENCY ROOM  
JULY 1952  
PATIENTS TREATED, BY AGE GROUPS

AGE	NO.	PER CENT	POPULATION
			NEW HAVEN CITY 1951, PER CENT
Under 5 .....	72	30.3	8.8
5-14 .....	85	35.7	12.6
15-64 .....	68	28.6	69.3
Over 65 .....	12	5.0	9.3
Unknown .....	1	0.4	—
	238	100.0	100.0

This has the effect of bringing school years into equal prominence with preschool years, although representing twice the time interval. However, the number of accidents occurring in five preschool years roughly approximates both those occurring in the ten school years and the fifty years of productive life. Is the preschool child the one most at risk of injury from accidents in the home? This is an age of adventure and exploration into a world full of unknown dangers, of experimentation, oral and tactile, which can lead the unsuspecting toddler to all kinds of perils. However, many of these injuries could be reduced by awareness on the part of the parent and by efforts to remove some of the sources of danger until the child is capable of avoiding them himself.

"Home" for the purpose of this survey was taken to include house, porch, yard, garage and driveway, although not the sidewalk in front of the house—the total area over which the householder has jurisdiction. Although it was impracticable to get details as to the exact location, it was sometimes possible to determine whether the accident had taken place indoors, or out, and occasionally to be more explicit. Of 153 cases where the location was known, 83 were "outside" accidents. With such a large number of unknowns it is impossible to draw conclusions. It would be expected that there would be a large number of outdoor accidents during the summer owing to longer hours of outdoor play, and it would be interesting to know whether these are replaced in

the winter by falls on icy steps and improperly swept paths.

In 52 cases more exact location was given. Eight accidents occurring in the garage and driveway were all connected with a car, either falling out of one, or fingers jammed in a car door. In one case the trunk lid fell on the patient's shoulder. Of five bathroom accidents, three were accidental poisonings, and one was a child who was cut while playing with a razor. Six of seven basement accidents were associated with tools, such as saws, hammer and nails, etc., and the seventh involved the washing machine. Those in the living room were mostly concerned with tripping over or banging into furniture. Six of nine accidents known to have taken place in the kitchen were cuts, two were burns, and one an accidental poisoning with furniture polish. There were 10 accidents due to falls on stairs.

Although chiefly of academic interest, a list was made of the various types of accidents.

TABLE 4  
HOME ACCIDENTS SEEN IN THE EMERGENCY ROOM BY TYPE  
JULY 1952

TYPE OF ACCIDENT	NO.	TYPE OF INJURY	NO.
Fall .....	78	Lacerations .....	135
Collision with object...	50	Sprains, contusions .....	40
Treading on object.....	27	Fractures .....	23
Cut by sharp object...	16	Foreign bodies .....	20
Burn .....	9	Burns .....	9
Poisoning .....	9	Poisonings .....	9
Dog bite .....	6	Concussions .....	2
Miscellaneous .....	17	—	—
Unknown .....	26		
Total .....	238	Total .....	238

Falls lead easily, including falls both from a height and on the level. Collision with objects, plus accidents caused by treading on objects, which was separated because of its size, and those cut by sharp objects, when combined as they are all of this same general nature, exceed the falls. Many objects were included in the collision group such as running into furniture, putting hand through window, fingers trapped, objects falling on victim. The grouping here was an attempt to gather together those accidents which involve other objects, not of themselves dangerous or presenting an obvious hazard. When grouped, these innocent objects seem to present a greater problem than those with more apparent dangers, such as knives, burns, and poisons.

Accidents caused by treading on objects were separated. There is probably a large seasonal element accounting for the size of the group. Nearly all of these accidents occurred in the yard, and the story usually reads "trod on nail" or "trod on glass." The back yards of New Haven must be bristling with old rusty nails and broken glass! Most of the victims were playing in the yard barefoot or inadequately shod. The wounds so caused were by no means trivial, but deep and dirty. This group represents a considerable sum of preventable pain and injury. It is not a Herculean task for a householder to keep his yard reasonably free of old pieces of board with nails sticking up, or seeing that all broken bottles and other pieces of glass are removed. Again, should children run barefoot, or in flimsy shoes over ground of doubtful safety? Apart from the danger of serious injury, the feet become easily scratched and thus present open wounds for soil organisms to enter. Among injuries caused by sharp objects were wounds due to objects normally intended for cutting and valued for their sharpness, including kitchen knives, a saw, lawnmower blades, a scythe, a fish-hook, a razor, and an axe. All of these are potentially dangerous objects which are used commonly, and it is surprising that more were not listed.

Burns and poisonings share next place. All the poisonings occurred in children under five. One of the burn cases was due to flaming gasoline. The next most serious was a grease burn from an overturned frying pan. There was one ammonia burn of the eyes and one scald from an overturned pan of boiling water. One burn was from handling an incinerator, and the rest were from fireworks. Considering that the Fourth of July was included in the time period under survey, this was a small crop.

Six dog bites, next on the list, were minor affairs. Fortunately, New Haven is free of rabies! Mostly the skin was hardly broken, and the fact that these cases turn up at the hospital is probably due to the peculiar fear of dog bites held by the general population. There were swallowed and inhaled foreign bodies, and obscure wrenches, twisted ankles, and others not included in the above groups. Most of the meagre information which was obtained for the miscellaneous was taken from the nurse's or orderly's notes. Lacerations are the commonest type of injuries. Some are the results of falls, as also are the sprains and contusions, and fractures. The fractures and concussions represent the most serious injuries,

many of the laceration injuries are much less serious. The large number of injuries to the foot include those due to treading on objects, as previously discussed. The hand is well represented in third place although it might be expected to be higher. Internal injuries include those to the throat, and foreign bodies in the lung and gastro-intestinal tract. The largest age group in the series, the under-fives, deserves special consideration in the table following. A large number of children who fell and cut their heads is probably correlated with the hazards of learning to walk and run. When the cut heads and cut faces are added together, they total nearly half of the accidents in this group. However, only two children suffered severe head injuries with definite signs and symptoms of concussion, and most of the injuries were fairly trivial. Too many probably involved cuts caused by corners of furniture and other sharp objects; but information on this group was extremely poor. Falls involving arms and legs totalled only seven, or one-tenth of the whole, the head thus appearing to bear the brunt of the burden. This may be related to the lack of coordinative skill at this age, as a child under five usually makes little attempt to break a fall with his arms, and has not fully developed his ability to recover his balance when it is disturbed temporarily. Probably little can be done at this age to eliminate falls, but training of parents to remove or minimize dangers from falling against sharp objects might reduce the injuries. The three lacerations by glass are also theoretically preventable, as children at this age should not be allowed to play with glass objects, nor should there be broken glass in the play areas.

Of the nine cases of poisoning, three children swallowed aspirin tablets when "mother was not looking," one being admitted. One was being treated for a sore throat, and the aspirin bottle was left within reach, and one apparently just sampled the tablets. One child swallowed demerol tablets when in the charge of its grandmother. One child tried a bottle of lysol which had been left on the bathroom floor, and another, adult cough medicine, apparently containing codeine. One child drank furniture polish taken from a kitchen cupboard, another drank some Flit, and another sampled cuticle remover left in the bathroom. Fortunately none of these episodes had very serious consequences, but point up the dangers of leaving anything which might be ingested at floor level, or within reach of exploring fingers. With a



TABLE 5  
HOME ACCIDENTS SEEN IN THE EMERGENCY ROOM OF  
NEW HAVEN HOSPITAL, JULY 1952  
ACCIDENTS TO THE UNDER-FIVES

TYPE OF ACCIDENT	NUMBER
Fell and cut head.....	17
Fell and cut chin, face or tongue.....	13
Drank poisonous substance.....	9
Fell and bruised arm or leg.....	5
Foreign body in throat.....	4
Hand or thumb trapped or crushed.....	4
Foreign body in eye.....	3
Cut extremity with glass.....	3
Swallowed solid foreign body.....	3
Fell and cut arm or hand.....	2
Dog bite on face.....	2
Subluxation of elbow.....	2
Foreign body in nose.....	1
Run over by car in yard.....	1
Furniture fell on.....	1
Burnt with grease.....	1
Trod on nail.....	1
	—
	72

little care and foresight all of these accidents could have been avoided.

Of the four foreign bodies in the throat, one was a fishbone in a child of three. One child of a year had a hard candy stuck in his throat. One child inhaled into his trachea some sand from a sand pit and another inhaled a small stone into a main bronchus. These last two were probably unavoidable occurrences, but the first two could have been prevented. Three of the four crushed hands involved car doors, and the fourth was due to a window pushed down on the child's hand.

The only two accidents which were reported in children under one year old were the one case where the child was run over by a car, and one of the lacerations of the head. Apparently the first child had been put out in its play pen. The mother and aunt, neither of whom knew how to drive, got into the family car which was standing in the driveway,

and reversed the car into the playpen, crushing the child in the debris. Luckily the child was not badly injured, and fortunately such examples are rare. The other child mentioned was left unattended on the parent's bed, and promptly fell off, and cut its head. Again the damage was not very serious, but this practice is asking for trouble.

This series of accidents to the under-five is most noteworthy in that the parents, or others looking after the child, must take part, if not all, of the responsibility for these mishaps. Until more parents understand the elementary precautions to be taken to make a home safe for a small child, the number of accidents in this age group will continue to be large.

#### CONCLUSIONS

While no sweeping conclusions can be drawn from these limited data, general trends can be extracted.

1. The deaths in New Haven follow the pattern of the home accident deaths of the rest of the United States. As elsewhere, they happen mostly to the elderly, and then to the very young, with a marked preponderance of deaths following falls.

2. Many non fatal home accidents occur in New Haven. About half of these cause disability for more than twenty-four hours.

3. A large number of children under five are involved in these accidents.

4. An opportunity is apparent for parent education.

5. In an emergency room, much can be learned about people and measures to prevent disability and illness.

6. Considerable preventable disability resulting from home accidents can be brought to the attention of medical students and house officers. Besides hospitals and medical and nursing schools, there is opportunity also for health departments, schools, and safety councils to assume more active roles in efforts to reduce home accidents and their resulting expenses, unnecessary incapacity and unhappiness.

## RECENT ADVANCES IN CANCER RESEARCH: A REVIEW

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## SUMMARY

A new era of biological philosophy has been entered with the use of radio-isotopes in research work on carcinogenesis and tumor metabolism. By such use of radio-isotopes our knowledge of hydrocarbon carcinogenesis is being increased, although as yet the exact mode of action of these carcinogenic carbons is not understood. Isotope tracer studies have been started in the field of tumors, studying the problems of metabolism and endeavoring to increase the knowledge available of the mode of action of hormones in cancer.

THE therapeutic aids now available in the treatment of cancer indicate the great progress made in the struggle against this disease through combined research efforts. They include multimillion volt irradiation therapy, cobalt 60 irradiation beams, new and more extensive use of radioisotopes, improved surgical techniques and antimetabolite drugs and hormones. Because of their effectiveness in combatting cancer, these agents have received much well deserved publicity. Their skillful application has returned many patients already to useful, productive lives. The purpose of this paper is to review some of the developments in the application of radio-isotopes to the problem of carcinogenesis and tumor metabolism.

Cancer is primarily a problem in growth. Cancerous growth capacity is apparently independent of the organism and, hence, the growth capacity of the tumor is a nearly unique property of the tumor itself. This property of autonomous growth is the most striking characteristic of tumors as a class, and within the factors responsible for this property lies the secret of the control of this growth.

The pioneer experiments of more than a quarter of a century ago resulted in a series of investigations using stable isotopes, and subsequently radio-isotopes, and resulted in one of the most important concepts of modern biochemistry, "the dynamic state of body constituents" and the concept of the metabolic pool. Up to this time there had been a rigorous separation of exogenous and endogenous metabolism. Now this latter concept was no longer tenable and a new era of biochemical philosophy began.

## METABOLISM OF CARCINOGENIC HYDROCARBONS

The contribution of chemical carcinogenesis to the field of oncology is one of considerable significance. It is a valuable tool for the production at will of a variety of tumors in experimental animals. Of perhaps greater importance, however, is the use of chemical carcinogens to provide a means of studying the mechanism or mechanisms of tumor production. It is a rather unique situation when a pure chemical compound induces a profound series of chemical and biological changes that result in cancer and thus it provides a challenging opportunity to study the phenomenon in biochemical terms. If it were possible to discover any metabolic sequence of reactions that were specifically affected by the carcinogens, then progress toward the prophylaxis and treatment of endogenous cancer would be materially advanced.

An extremely important discovery was made when it was demonstrated that benzpyrene, one of the chemical carcinogens, applied to the skin of mice was bound to protein.<sup>1</sup> This has been shown to occur with several of the hydrocarbons. It would seem almost axiomatic that a chemical carcinogen should produce this biological effect as a result of a chemical interaction with some important cellular component, and the demonstration that such an interaction actually does take place provides the impetus for a new approach to the problem. Techniques have been developed which make possible the study of such an interaction with various cell



fractions and nucleic acids derived from certain tissues of mice. By means of techniques which will fractionate tissues into well defined nuclear, large granule, small granule and supernatant parts, investigations are now underway to ascertain the exact components of the cell with which the hydrocarbon reacts. It may be possible by experiments of this sort to determine whether the hydrocarbons are reacting with desoxyribose nucleic acids and causing mutation, or whether their action is primarily on the cytoplasm, possibly by causing the deletion of some essential enzyme. In any event, it is hoped that studies of this sort will make possible a clearer understanding of the mode of action of the carcinogenic carbons.

In summary, the use of radioactive isotopes is contributing to our knowledge of hydrocarbon carcinogenesis by: (1) providing quantitative information on the distribution, excretion and rates of elimination of carcinogens; (2) identification of metabolites and metabolic sequences of carcinogens; (3) determination of site or sites of interaction of carcinogens with the cells; and (4) providing methods for study of the effect of the carcinogens on metabolism of sensitive and resistant tissue. It is to be hoped that this rather comprehensive approach to the problem may provide some clues, not only to the mechanism of carcinogenesis but also to methods of preventing or controlling the neoplastic transformation.

#### OXIDATIVE METABOLISM OF TUMORS

Among the most important experiments of the pioneers in the field of cancer biochemistry were those of Warburg during the 1920's. Experiments undertaken with the tissue homogenate technique showed a diminished level in tumors of cytochromes and certain enzymes involved in Krebs cycle oxidations compared with the more metabolically active normal tissues. Under certain circumstances, the failure to observe Krebs cycle oxidation in homogenates suggested the possibility that one or more key steps in the Krebs cycle might be very low or absent in tumors. A difference as fundamental as this between tumors and normal tissues would be of great importance and this intriguing possibility has stimulated further investigation along these lines.

One observation that was unexplained was that tumor slices had an appreciable oxygen uptake which, however, could not be stimulated significant-

ly by the addition of Krebs cycle substrates. Thus, it was not clear whether the oxidation was taking place by other pathways altogether or whether the oxygen uptake was caused by such a high endogenous level of Krebs cycle intermediates that further addition of these substrates failed to cause further stimulation. An obvious way to test these alternatives was to add labelled Krebs cycle intermediate to tumor slices and measure the rate of their conversion to radioactive carbon dioxide. Thus, isotopic tracer studies were initiated into this field.

The oxidation of radioactive carbon acetate to radioactive carbon dioxide in slices in homogenates of a number of normal tissues was studied.<sup>2</sup> There was a significant conversion of acetate to carbon dioxide in slices of the normal tissue studied and considerable evidence was obtained to indicate that the oxidation took place by the Krebs cycle. In slices of transplantable rat tumor, however, less than  $\frac{1}{25}$ th as much radioactive carbon dioxide was produced as in kidney, an amount well below that which would be significant in oxygen uptake experiments. It was concluded that either the Krebs condensation reaction takes place to only a very limited extent in tumors or that tumors are less able to activate acetate than several normal tissues.

While this work was in progress it was announced that pyruvate-2-carbon  $^{14}$  was oxidized to radioactive carbon dioxide to about an equal extent by slices of normal liver and primary liver tumor.<sup>3</sup> These findings were confirmed in transplantable tumors and the results were consistent with the idea that pyruvate was oxidized by the Krebs cycle, although once again it was found that acetate was only slightly oxidized under these conditions. It seems likely that the conditions for maximum conversion of radioactive carbon acetate to radioactive carbon dioxide are not the same as for the conversion of radioactive carbon pyruvate to radioactive carbon dioxide in tumor slices. Further studies on this point are needed.

Carbohydrate metabolism similarly has been studied using labelled glucose in slices of liver and hepatoma. It was found that there is a greater production of radioactive carbon dioxide in glucose by hepatoma than by liver slices. It must be emphasized that rat liver slices have an especially low activity for this conversion. There was a less noticeable difference between tumor and liver when labelled fructose was the substrate. It was also found that

there was a greater incorporation of radioactive carbon into protein of liver neoplasm than into liver protein itself, and the amino acids obtained upon hydrolysis were essentially those of normal protein. It appears that there is a quantitative but no qualitative difference in the oxidative pathways in hepatomas and liver; and the synthetic processes such as those of protein occur more rapidly in tumors. On the whole, then, most of the evidence indicates that the Krebs cycle proceeds in tumor tissue but also indicates that it is of a very low order of activity since it is less than spleen, one of the normal tissues of relatively low oxidizing capacity.

Experiments involving whole animals poisoned with a tissue poison such as fluoroacetate showed that citrate does not accumulate in tumors as it does in most normal tissues, and suggest that some additional factors operate in the intact animal to regulate either the Krebs cycle oxidation or closely related processes. Additional information is available concerning the incorporation of labelled amino acid glycine into the proteins of the mouse liver, kidney, intestine and muscle. It has been demonstrated that this process in animals treated with adrenocortical extract or cortisone was diminished. These hormones, however, had no effect upon the incorporation of the isotope into the protein of a transplantable mammary adenocarcinoma. This type of research appears to be a promising approach to the understanding of the mode of action of hormones in cancer.

#### CONCLUSION

This review emphasizes the application of an important and general technique which has been used in many fields and covers in particular several areas of oncology. Isotopes have made a substantial contribution to this field. The isotopic tracer technique has only recently become available as a tool, yet it can be used in almost any laboratory concerned with problems in metabolism in applying it to the special metabolic situation. It seems likely then that in the not too distant future there will be available a description of the metabolism of nearly every individual metabolite in terms of the alternate pathways that it pursues in different organisms, in different tissues and under a wide variety of special situations. With this knowledge may come the ability to influence the metabolism along specific lines by means of substitution in the case of deficiencies and by the use of antimetabolites and other types of enzyme inhibitors that will modify enzyme action. It is this reviewer's firm belief that intensive and productive research along the lines here briefly described will eventually supply the answer to many of the enigmas that are collectively known as cancer.

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## SOME NOTES ON CHRONIC PROSTATITIS

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### SUMMARY

One hundred twenty-four consecutive cases of chronic prostatitis were reviewed with reference to differential diagnosis, symptomatology, age, etiology, cultures, therapy, persistence or absence of organisms, and recurrences.

Elkosin was effective for most cases of staphylococcus and streptococcus infections, mixed infections, *E. coli* and *B. proteus*, but was ineffective for pseudomonas, Friedlander's and trichomonas prostatitis. The trichomonas responded favorably to Aureomycin therapy. The pseudomonas and Friedlander's have persisted and are still being followed, although the patient's symptoms have been relieved, at least for the present.

CHRONIC prostatitis is one of the commonest diseases which the physician sees as part of his practice of "office urology." It is also sometimes one of the stubbornest to treat rapidly and effectively even with the new antibacterial agents now available, in contrast with gonorrheal urethritis and other acute venereal afflictions.

An occasional patient, surprisingly enough, will express disappointment on being told that he has chronic prostatitis and not gonorrhea. I imagine the reason for this is that somehow he has found out that gonorrhea responds quickly and miraculously to penicillin and other wonder drugs, whereas prostatitis usually will not.

This study is based on 124 consecutive cases of prostatitis seen in a 3 year period. All patients with spontaneous urethral discharge had smears and cultures to rule out gonorrhea.

The experienced physician can usually tell, by inspection of the discharge coming from the external urethral meatus, whether the patient has gonorrhea or not; in gonorrheal urethritis, the discharge is thick and yellow, whereas in prostatic urethritis, it is thin and whitish or off-white. In all suspicious cases Gram stain of the discharge will demonstrate whether the gonococcus is present, and, if so, penicillin is still probably the treatment of choice.

Any patient with a spontaneous urethral discharge should have an immediate Gram stain in order to settle the question of gonorrhea as soon as possible as well as to act as a guide in therapy. Many patients with a nongonorrheal urethral discharge have been treated with penicillin to no avail, as the nongonorrheal discharges usually will not respond to penicillin. I never massage the prostate of a patient with acute gonorrheal urethritis. It is not necessary and may cause complications such as epididymo-orchitis, and that is another reason for having the Gram stain done as soon as the patient is seen to rule out gonorrhea in or out in suspicious cases.

Gonorrheal smears and cultures may be sent to the State Health Laboratory in Hartford, in the G C and N C containers, respectively.\* This may be done in positive cases for confirmation, and in suspicious cases when you are not satisfied with your own Gram stain. While awaiting report of the latter (suspicious cases), penicillin therapy is indicated and justifiable. However, it is most unusual to make a mistake in examining fresh Gram stained specimens. We have agreed with the State Health Laboratory

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\*The State Health Laboratory discontinued gonorrheal cultures July 1, 1953.

100 per cent in ruling gonorrhea in or out on Gram stain.

Inasmuch as we are not here concerned with acute gonorrheal urethritis except to rule it out, we shall turn our attention to chronic prostatitis.

SYMPTOMATOLOGY

Urinary tract symptoms (discharge, burning, frequency).....	76
Prostatitis found during infertility workup.....	14
Referred for investigation of pyuria.....	9
Hemospermia (seminal vesiculitis).....	8
Impotence .....	5
Testicular pain and discomfort.....	4
Itching, tickling in the urethra (all had trichomonas).....	4
Rectal burning ("like a hot potato in the rectum").....	2
Peyronie's disease .....	1
Urinary frequency thought to be prostatism (age 72).....	1
	124

AGE

The age range was from 16 to 72. The greatest number of cases occurred in the age 20 to 40 (third and fourth decades) as might be expected, this being the period of greatest sexual activity in most men.

Eleven of the patients were over 50 years of age, and when first seen were thought to be suffering from symptoms of prostatism presumably due to enlargement of the prostate. However, all had residual urine of less than an ounce; on cystourethroscopy, none had trabeculation of the bladder; the prostate did not appear to be enlarged intra-urethrally. The prostatic fluid was full of pus clumps and the prostate was tender and boggy rather than enlarged on rectal examination.

These "elderly" patients were relieved of their symptoms by treatment directed to their prostatitis—weekly massage, antibacterial therapy and Sitz baths.

An interesting sidelight, which should not be a surprise to anyone, is that the older the patient, the longer it usually took to relieve him of the prostatitis.

ETIOLOGY

It is generally stated that "sexual excitement without gratification" is one of the principal causes of bringing on prostatitis. We would also add "prolonged or repeated sexual excitement." However, we failed to elicit such cause in the recent past in approximately one-third of the patients.

In a review of the past history, 75 per cent of the patients denied ever having had gonorrhea, and 25

per cent admitted that they had had the disease. The significance of this is unknown. Gonococci were found in the prostatic strippings of one case (incidence of 0.8 per cent) in the present series.

CULTURES

Of the 124 cases, cultures of prostatic fluid were obtained in 111 cases. In the other 13, the amount of prostatic fluid obtained was too scant to permit a culture, although enough was obtained for smear. A wet smear, unstained, covered with a cover slip, is the best way of determining the amount of pus and pus clumps in the prostatic fluid.

Prostatic fluid cultures and wet smears are obtained as follows: The meatus and glans penis are cleansed with an antiseptic solution such as oxy-cyanide of mercury 1:1,000 or Bactine 1:4. The prostate is massaged and the prostatic fluid allowed to drip into a sterile bottle supplied by the State Health Laboratory in the M I container.† After this, a few drops are collected on a clean slide and covered with a cover slip, for low-dry and high-dry examination.

One of the interesting findings is the high percentage (37 per cent) of sterile specimens, wherein the Laboratory found no bacteria on smear or culture of the prostatic fluid.

RESULTS OF INITIAL CULTURES OF PROSTATIC FLUID—111 CASES

No growth (no organisms found on smear or culture, although all had pus clumps on wet smear).....	41 (37%)
Staphylococcus non hemolytic (in pure culture).....	35 (32%)
Mixed cultures .....	18 (16%)
(10 of these were a mixture of non hemolytic Staphylococcus and non hemolytic Streptococcus)	
Streptococcus, various species.....	10 (9%)
E. coli .....	2
Pseudomonas aeruginosa .....	2
Proteus vulgaris .....	1
Friedlander's bacillus (Klebsiella).....	1
N. gonorrhoeae found in prostatic fluid.....	1
Total .....	111

Role of Pleuropneumonia-Like Organisms—Because of the fact that PPLO have been implicated by some investigators as the causative agents in chronic prostatitis and nonspecific urethritis, six of the above cases of chronic prostatitis seen at the Newington Veterans Administration Hospital were

†The State Health Laboratory discontinued doing MI (miscellaneous cultures) on July 1, 1953.



cultured for pleuropneumonia-like organisms, and all of these were negative for PPLO.

Role of *Trichomonas*—*Trichomonads* were found in the wet smear of the prostatic fluid of four cases, an incidence of 3 per cent. Of these four, two showed no growth of bacteria on routine culture; of the other two, one showed non hemolytic staphylococcus and the other non hemolytic streptococcus.

Because of the varied nature of the organisms found, as well as the significantly high number of negative initial cultures (37 per cent), we must continue to call this condition "nonspecific urethritis and prostatitis." Perhaps the word "abacterial" should be substituted for nonspecific. Wagner et al<sup>1</sup> were similarly unable to demonstrate an agent or agents which could be considered etiologic or specific.

#### THERAPY

It is difficult to run a truly controlled series of cases in evaluating the results of therapy of chronic prostatitis.

In the beginning of this series, treatment was more or less indiscriminate, depending on cultures and whatever drug I thought would be suitable in a particular case, as well as a consideration of the cost of the broad spectrum antibiotics (Aureomycin, Chloromycetin and Terramycin) and their side effects. It seemed to me later in going over the cases that the results with these relatively expensive drugs were no better than with the newer sulfonamides—Gantrisin and Elkosin. Furthermore, chronic prostatitis is a relative innocuous disease requiring no heroic efforts—mortality is zero and morbidity is relatively slight—and you would not use an elephant gun to shoot at a rabbit. Therefore I am in favor of using the expensive, powerful, somewhat dangerous broad spectrum antibiotics where they are more desperately needed—virulent infections, etc.

In general, the broad spectrum antibiotics were given 4 times a day in 100 mg. doses for seven days. The Gantrisin and Elkosin were given 4 times a day for 7 days in 1 Gram doses.

At first Gantrisin was used for the majority of cases, and then, when Elkosin became available, most cases were treated with this new sulfonamide. The latter proved to be unusually well tolerated, free of side effects, and efficacious, so that at present I am using it almost exclusively, except in the following cases.

1. It is ineffective in clearing trichomonas prostatitis and urethritis. Aureomycin proved to be very effective for this after Elkosin had failed.

2. It has been ineffective against pseudomonas aeruginosa (*B. pyocyaneus*) even after being given for two or three "courses" of treatment of one week each (two cases).

3. It was ineffective in getting rid of a persistent Friedlander's infection of the prostate.

4. There are apparently some few strains of staphylococci that appear to be resistant to Elkosin. It is possible that erythromycin would be efficacious in these cases and should be tried if the symptoms and signs warrant.

A tabulation of "Bacteriologic Success" (prostatic fluid cultures from positive to negative promptly after treatment) shows the following:

Elkosin therapy exclusively.....	58 cases
Bacteriologic clearance .....	32 (80%)
Bacteriologic "failure" .....	8
	—
	40
No growth on initial culture.....	15
Insufficient follow up.....	3
	—
Total .....	58
Gantrisin therapy exclusively.....	31 cases
Bacteriologic clearance .....	13 (68%)
Bacteriologic failure .....	6
	—
	19
No growth on initial culture.....	7
Insufficient follow up.....	5
	—
Total .....	31
Broad spectrum therapy.....	10 cases
Bacteriologic clearance .....	4 (66%)
Bacteriologic failure .....	2
	—
	6
No growth on initial culture.....	1
Insufficient data .....	3
	—
Total .....	10

Penicillin Therapy—Penicillin alone was used for one case of Gc prostatitis and proved to be efficacious in clearing the prostatic fluid of gonococci; the pus clumps in the fluid disappeared by the 4th prostatic massage, and the culture was sterile. This patient did not have a urethral discharge. He had had acute gonorrheal urethritis treated with penicillin six

months previously, and apparently now had a "specific," i.e., gonorrheal prostatitis.

Sulfadiazine was used early in this series for four cases:

Bacteriologic clearance .....	3 (75%)
Bacteriologic failure .....	1

This drug was then abandoned in favor of the more soluble, safer sulfonamides, Gantrisin and then Elkosin. As mentioned above, after all prostatitis is not a very serious disease and one should not take chances with a drug that is more apt to cause crystalluria and other side reactions. In point of fact, Elkosin was developed precisely to be less toxic and safer to use than early sulfonamides.<sup>2</sup>

Mandelamine was used for three of the four cases of trichomonas prostatitis. It proved to be efficacious in one case, but not in the other two. Elkosin was also used for these two and was also ineffective, but one course of Aureomycin, 100 mg. four times a day for seven days, was effective in eradicating the trichomonads in one week.

Cases which received no antibacterial therapy.....	20
Showed no organisms on initial culture.....	8
Cultures not done due to scant amount of fluid.....	5
Treated without drugs, failed to clear.....	3
Treated without drugs, and did clear.....	1
Insufficient data .....	3

It would seem, therefore, in comparing this small series that antibacterial therapy is valuable in most cases of chronic prostatitis—of the patients not given antibacterial drugs, three out of four failed to achieve bacteriologic clearance, whereas of the patients treated with drugs of various kinds, 72 per cent promptly cleared bacteriologically, and incidentally were symptom free in a much shorter time.

PERSISTENCE OF BACTERIA

Certain cases showed a persistence of the same organism week after week, indicating that, in these cases at least, it was undoubtedly the infecting organism.

S. R. Age 47. Impotence and chronic prostatitis. Non hemolytic staphylococcus was cultured on six consecutive cultures of prostatic fluid. This failed to clear with Gantrisin. Finally obtained sterile culture after two weeks of Elkosin, 0.5 Gm. four times a day. Rather close correlation here between amount of pus cells in prostatic fluid, symptoms and cultures, although this does not always obtain.

H. V. Age 60. Referred for pyuria. E. coli found on two consecutive cultures of prostatic fluid; this cleared on Elkosin. Then suffered a recurrence, or relapse, with E. coli in prostatic fluid and in urine on four consecutive cultures. Complete GU survey showed only chronic prostatitis with

a mild benign prostatic hypertrophy. Cleared again on Elkosin therapy.

B. S. Age 62. Referred for frequency and pyuria. Pseudomonas aeruginosa found on seven consecutive cultures of prostatic fluid and urine. Unable to clear this on Gantrisin, or Mandelamine, or two courses of Elkosin. Complete GU survey showed only chronic prostatitis. Still under observation—no treatment at present as symptoms have been relieved and pyuria markedly diminished.

C. F. Age 42. Peyronie's disease and chronic prostatitis. Non hemolytic staphylococcus found on five consecutive cultures of prostatic fluid. Given only Eprolin (R) (alpha tocopherol) 100 mg. three times a day for the Peyronie's disease, and no antibacterial therapy for the prostatitis, although he did receive weekly massages and took nightly Sitz baths. The non hemolytic staphylococcus in the prostatic fluid persisted, week after week. Then he was given Elkosin 0.5 Gm. four times a day for two weeks and the next culture of prostatic fluid showed no organisms on smear or culture. This case is one wherein the antibacterial therapy with Elkosin would appear to have been efficacious in clearing the prostatic fluid of a persistent organism. The prostatitis has subsided, but the Peyronie's disease persists, although it has not progressed.

S. H. Age 50. Referred for pyuria and frequency. Found to have multiple prostatic calculi and chronic prostatitis on complete urological study. Pseudomonas aeruginosa found in the prostatic fluid on four consecutive cultures, although the urine was sterile. This organism persisted in the prostatic fluid despite Elkosin therapy. Given Aureomycin 250 mg. three times a day for seven days and the prostatic fluid culture was sterile the next three times. Then the pseudomonas recurred in the prostatic fluid culture five weeks later. The patient now has clear urine, which is negative microscopically, and is asymptomatic, despite findings of pus and bacteria in the prostatic fluid. I feel that this patient should be left alone unless and until the symptoms recur.

S. V. Age 29. Referred for infertility workup, and found to have chronic prostatitis. Six consecutive prostatic fluid cultures were positive for non hemolytic staphylococcus. This did not clear until the patient had had three courses of Elkosin (1 Gm. four times a day for seven days each time), and then the prostatic fluid culture was sterile—no organisms found on smear or culture. The prostatic fluid meanwhile had gradually returned to near normal.

P. M. Age 47. Urethral discharge, urinary frequency and burning. Prostatic fluid culture persistently positive for non hemolytic staphylococcus for three consecutive weeks. Penicillin therapy given for suspicion of Gc (not proven) failed to clear the staphylococci and had no effect on the discharge. Culture of prostatic fluid became sterile after 10 days of Elkosin therapy. Discharge disappeared after third prostatic massage.

F. R. Age 60. Urethral discharge, frequency. Prostatic fluid persistently positive for Friedlander's bacillus on four consecutive cultures. Failed to clear on Mandelamine or Elkosin. Still being followed. Symptomatically relieved by massages. The drug therapy seemed to have no effect on the morning drip.



C. J. Age 45. Heavy yellowish-white urethral discharge, negative for Gc but positive for non hemolytic staphylococcus and alpha hemolytic streptococcus. Treated with penicillin at first—organisms persisted in the prostatic fluid. Then given Elkosin, 1 Gm. four times a day. The next three prostatic fluid cultures were all negative for bacteria on smear and culture, although the heavy urethral discharge and purulent prostatic fluid persisted for one month. It took only one week to achieve "bacteriologic clearance" with Elkosin, but it took four weeks of massages and Sitz baths before the clinical symptoms and signs cleared.

M. S. Age 40. Referred for infertility and chronic prostatitis. This case represents persistent absence of bacteria—although the prostatic fluid and seminal fluid were loaded with pus cells and pus clumps, five cultures of prostatic fluid and a urine culture were all free of organisms on smear and culture. The prostatic fluid finally cleared of pus clumps by the fifth massage, although there were still 25-30 pus cells per high power field in the wet smear. This patient's wife ultimately was delivered of a normal child, two years after the treatment for chronic prostatitis was begun, and one and one-half years after it had been stopped.

#### RECURRENCES

Reinfections or recurrences or relapses (call them what you will) were not uncommon. Twenty-six of the 124 patients (21 per cent) returned with a recurrence of their complaints and with the prostatic fluid full of pus clumps again. It is a question whether a patient with chronic prostatitis is actually cured; as long as he has his prostate he can certainly get prostatitis again. However, I am not advocating removal of the prostate to cure or prevent prostatitis. The condition of chronic prostatitis may be likened to chronic sinusitis—as long as the patient has sinuses he is a potential candidate for sinusitis, and those who have had prostatitis or sinusitis are apt to have a recurrence of their trouble from time to time.

Most of the patients with recurrences gave a history of sexual and alcoholic indiscretion. Occasion-

ally recurrence followed exposure to the elements, a bad cold, overactivity in work or play, etc. Therefore, those are the facts that can be mentioned to the patient when he asks the question (as most do), "Doctor, will I get cured, or can I ever get this condition again?"

#### CONCLUSIONS

We feel that chronic prostatitis is best treated by prostatic massage, preferably once weekly, and for six weeks if necessary, followed by a six weeks' rest period, together with antibacterial therapy, depending on the prostatic fluid smear and culture, and Sitz baths every night. Alcohol and excessive sexual excitement are contraindicated during treatment.

We do not feel that the broad spectrum antibiotics are indicated in the usual case of chronic prostatitis. They are relatively expensive, but, more important, are apt to be more dangerous than the disease under treatment."

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Most of the Elkosin (R) used in this study was kindly furnished by Ciba Pharmaceutical Products, Inc., Summit, N. J.

## ERGOTAMINE TARTRATE AND CAFFEINE (EC 112) IN MIGRAINE HEADACHES

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### SUMMARY

A series of 28 patients with migraine headaches were given a therapeutic trial with EC 112, a preparation containing ergotamine tartrate and caffeine. The results presented show that the rectal route of administration is an effective one. One suppository was usually sufficient to control symptoms in an hour. This type of medication was found to be effective in patients known to respond well to ergot by other methods of administration and should be used when oral or parenteral routes of therapy are either not tolerated or are not feasible.

HEADACHE is one of the commonest symptoms encountered in medical practice. The various types of cephalalgia and the diversity of treatments recommended have been the subjects of many clinical and experimental studies in recent years. Migraine is probably the most important of the severe types of headache.

The etiology for migraine has not been established, so that no definite cure has as yet been developed. The best that this type of patient can hope for at the present time, therefore, is some effective means of terminating the attacks; therefore, the average migraine patient is extremely grateful for any type of therapy that will give him rapid symptomatic relief. The literature contains many reports of various types of medications said to be effective in terminating migraine attacks, i.e., the anticonvulsants, such as Mesantoin, Dilantin; histamine; anti-histamines; Octin, Amphetamine and its derivatives; hormones, vitamins, especially nicotinic acid, riboflavin and thiamin; caffeine; oxygen, etc. On the whole, these are effective in only a very small percentage of patients.

In general, the majority of investigators have found ergotamine tartrate (Gynergen), and such derivatives as DHE 45 to be the most effective weapons in our present armamentarium. These preparations are usually given orally or parenterally. Although these agents are most effective, their use nevertheless presents certain disadvantages which must be considered. The oral form of therapy is fairly effective, either when administered by itself as ergotamine tartrate or combined with caffeine (Cafergot). Greater effectiveness is obtained when the drug is taken very early in the prodromal phase; otherwise the patient may become too nauseated to retain the medication. Then too, the oral route may be ineffective as the medication itself may cause further nausea and vomiting. In this event, additional doses (and it is a well known fact that most patients require more than one dose to abort the migraine attack) by the oral route are of little value.

The sublingual route has been used, but here too, an intensification of retching and vomiting has often been reported. The hypodermic use of either Gynergen or dihydroergotamine methanesulfate (DHE 45) is very effective and rapid in its onset. However, the administration of these drugs requires the presence of a person to administer them. The delay caused by the fact that the second party may not always be immediately available is certainly a disadvantage to parenteral medication. Very few migraine patients can be taught to inject themselves with these drugs. Often the dosage they may thus inject is not accurate for many reasons and then, too, occasionally the side reactions can be so severe that presence of another person is most desirable.

### GROUP TREATED AND MATERIAL USED

The present report deals with the use of a rectal suppository, EC 112, Sandoz, containing 2 mg. of ergotamine tartrate and 100 mg. of caffeine which we employed in order to overcome some of the above mentioned disadvantages to both the oral and parenteral routes of administration of ergotamine and its derivatives. The patients were instructed to



use one suppository immediately upon the onset of the prodromal symptoms and to repeat this dose in one hour if no relief was obtained. The usual precautions in employing rectal medications were followed (e.g., refraining from using refrigerated suppositories in order to avoid delay in melting and absorption, retaining the suppository until it is fully melted, etc.). It is readily seen that this method of administration overcomes the objections to the oral and parenteral preparations. In addition, suppositories can be administered without special equipment and are relatively inexpensive to the patient.

The usual classical migraine attack was described by all of these patients. Their headaches occurred at any time of the day or night and lasted anywhere from one hour to as long as four days. Patients ranged from twenty years of age to forty-eight years of age. Some had had headaches for only one year while one patient had suffered from migraine episodes for thirty-three years. The age of onset in this series extended from fifteen years of age to forty years of age.

#### RESULTS

The above group of 28 patients were given EC 112. All of them had previously been treated with other agents with only fair results: e.g., Octin, Valoctin, nicotinic acid, histamine, antihistamines, sedatives and analgesics. Cafergot had been effective in only a few cases, while Gynergen and DHE 45 gave uniformly good results despite the fact that a few of these patients had severe gastrointestinal upsets after getting the medication parenterally.

The results with EC 112 are summarized in Table 1. Nineteen of the 28 patients reported uniformly good results with this preparation while 7 noted some improvement over the other. Two did not receive any benefit with this preparation. It is interesting to note that these two failures had previously obtained excellent relief with parenteral therapy. Improvement in the successful cases was noted as early as twenty minutes (one patient took four hours) with the greatest number of cases being relieved in about 1 hour. A second dose was rarely required. Side effects were at a minimum; proctitis did not occur and no real increase in nausea or vomiting was reported. Although other investigators have reported the occurrence of palpitation, nervousness, anxiety reactions, diuresis and diarrhea, not one of our patients developed such a reaction.

TABLE 1

## RESULTS

PATIENT	GOOD	IMPROVED	POOR	TIME
1	X			1 hour
2		X		2-4 hours
3	X			1 hour
4	X			1 1/2 hours
5	X			1 hour
6	X			3/4 of an hour
7	X			1 hour
8		X		2 hours
9		X		3 hours
10		X		3 hours
11		X		4 hours
12		X		3 hours
13	X			1 hour
14	X			1 hour
15	X			1 hour
16	X			1 hour
17	X			1 hour
18	X			3/4 of an hour
19	X			1/2 hour
20	X			1/2 hour
21	X			1 hour
22	X			20 minutes
23	X			1 hour
24	X			1 hour
25	X			1 1/2 hours
26		X		2 hours
27			X	Failure
28			X	Failure

#### DISCUSSION

In trying to determine a method of treatment that would provide adequate relief for these 28 patients, it was felt necessary after employing all the aforementioned drugs to review the patients' case histories to discover any common factors influencing medication. A complete physical examination was performed on all these patients and failed to show any other condition to which the medication failures might be ascribed. Discussed below are the findings obtained from the study of migraine attack in these case histories.

*A. Contributing causes*—20 of these patients developed migraine attacks following emotional stress. Eight of the 19 women developed their attacks at the time of their menstrual period and 23 of the 28 patients reported that physical fatigue precipitated their attacks.

*Comment*—An effort was made to discuss the environmental stresses to which these patients were subjected with them in order that they might readjust their activities to prevent themselves from

becoming physically fatigued. The emotional aspects of their condition were discussed with all migraine patients. These particular individuals apparently required a great deal of extensive explanation of the relationship between emotional stress and headaches. After reviewing this relationship more carefully with them it appeared that the frequency of some attacks was considerably reduced.

B. *Prodromata*—Every one of these patients reported that they were subject to one or more phenomena prior to the development of the severe headache. These symptoms varied. Seven visual symptoms were reported, 5 had gastric upsets, 9, various psychologic upsets, 4, vasomotor instability reactions, 18 were hypersensitive to noise, 15 were hypersensitive to light, 6 noted stiff neck and 9 experienced frequency of urination.

Comment—On the basis of these various prodromal symptoms these individuals were repeatedly instructed as to the importance of taking medication at the first signs of an attack. Many of these migraine patients, because of their peculiar personality makeup, frequently feel that the attack that has started will disappear before their head pain becomes too severe and they are always hoping to be “able to ride this one out.” They dislike admitting even to themselves that they require medication and for this reason often wait too long before resorting to the prescribed drugs. It takes repeated admonitions to get many of these individuals to use their medication in large enough doses early enough.

C. *Associated symptoms during the headache—*

Lacrimation .....	9
Diplopia .....	11
Photophobia .....	26
Sweats .....	10
Feeling cold .....	16
Anxiety reactions .....	15
Weakness .....	19
Nausea .....	26
Vomiting .....	25
Frequency of urination.....	16

Comment—It was obvious from these findings that the nausea and vomiting was the factor leading to poor therapeutic responses to various types of all medication. It was this observation and the difficulties encountered at times with the use of parenteral medication that led to the use of rectal suppositories containing 2 mg. of ergotamine and 100 mg. of caffeine alkaloid.

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## NEUROSYPHILIS PRECIPITATED BY TRAUMA: A CASE REPORT

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## SUMMARY

A case is presented of mild head injury acutely precipitating symptoms of central nervous system syphilis of a mixed type. The resulting severe taboparetic symptoms disclosed a silent lesion in an advanced state.

MILD head injury may produce severe neurologic symptoms by unmasking latent neurosyphilis which flares up by the shock of injury. Emphasis has been placed on an extended time interval between the injury and onset of neurosyphilitic symptoms.<sup>1</sup> This case is reported because taboparetic symptoms previously absent, appeared immediately after a moderate head injury.

A. K., a lumberjack, age 46, was brought to the hospital on February 12, 1951 in a dazed condition, after a head injury. Two and a half hours before, while piling logs with a tractor and chain, a sapling struck him on the left side of the head. He was knocked down, and on trying to get up he found he had no strength in his arms or legs. He was helped up and driven 75 miles to the hospital. There, he was ambulant with assistance. His skin was pale, he was stuporous but responsive. Blood pressure was 130/60, pulse 88. His arms dangled weakly and his feet shuffled. The pupils were moderately contracted, non responsive to light, and fairly regular.

A hematoma over the left frontal bone was 2½ inches in diameter, with a soft center. There was no bleeding from the ear, no evidence of cranial injury. X-rays of the skull and neck showed no fracture, dislocation or other abnormality. Arms showed no evidence of injury.

During the first 24 hours pain in the shoulders and hands was his only complaint. On the next day because he could not void he was catheterized and put on tidal drainage. Re-examination showed no skin reflexes, absence of knee jerks, and a foot drop on the right side. His temperature, pulse and blood pressure remained normal.

Lumbar puncture showed a pressure of 260 mm. of water with a cell count of 70 per cubic mm., mostly lymphocytes and a Pandy of four plus. The blood showed a four plus Wasserman and the spinal fluid Wasserman was four plus with a paretic type of gold curve.

The patient stated that he was single and denied venereal disease. He had had no sex contact for many months. He stated that he "is a strong man and has never been sick." He has worn thick glasses for 10 years, and remembers that he "hurt his eyes in early childhood when he fell down stairs." He gave a clear account of his accident which was corroborated by his employer and others.

Examination five days after the injury revealed no pain, numbness or headache. There was still weakness in both hands, he could not feed himself or get out of bed unassisted, and voiding difficulty was still present. There was bilateral wrist drop and right foot drop. There were no visual disturbances, and optic discs were well outlined. Pupils were fixed to light but did react to accommodation. Fourth and fifth nerves were intact. Sixth nerve examination showed paresis of left external rectus muscle, the other cranial nerves were normal.

Weakness of the intrinsic muscles of the hands and of flexion and extension at the wrists and of flexion at the elbows were noted. The right foot showed loss of flexion and extension. There was sensory impairment bilaterally on the posterior aspects of both arms. Reflexes were diminished in upper and lower extremities. Abdominal and cremasteric reflexes were absent bilaterally. Vibratory sense was diminished to absent from the knees down. Temperature sense was impaired only over the right calf.

On February 16 the patient was put on a 10 day course of penicillin, 2,000,000 units a day. On February 25 terramycin, 1 Gm. a day, was started and continued for 10 days. He also received 10 mg. of thiamin chloride t.i.d. orally, with 100 mg. of thiamin chloride t.i.d. intramuscularly. Pain gradually disappeared from the upper extremities and his ability to walk improved. He was able to void spontaneously and discard the Foley catheter which had been carried for five days more after three days of tidal drainage. A second course of penicillin was begun on March 2, 1951. Strength in his hands returned, he was able to take care of himself, but unilateral steppage gait remained.

On April 26, 1951, he was inoculated with malaria, and fever first appeared on May 7. He was permitted to have 15 paroxysms with temperatures up to 105°, the last occurring on May 30. The malaria was promptly controlled with chloroquine. Some foot drop and steppage gait were still present after the malaria therapy.

The patient displayed a healthy attitude and expressed a desire to go back to work. He was examined by a neurosurgeon and was declared fit to return to his occupation.

## DISCUSSION

This case is reported because it is uncommon. A vigorous, healthy, middle-aged adult engaged in a heavy occupation was struck on the left forehead while at work leaving him dazed and unable to use his limbs. Fixed pupils were noted on admission. It became clear that his severe symptoms were due not to injury alone but to neurosyphilis, aggravated by trauma. The bladder paralysis and severe pain in the shoulders shooting down the arm were suggestive of tabes, and the euphoria was considered typical of paresis. The extreme weakness of the hands suggestive of spinal atrophy involving the anterior motor horn cells may be classified as "syphilitic polio."

Trumpeer<sup>2</sup> states "it is fair to conclude that a given injury to the head in a non paretic syphilitic is responsible for the paretic signs which follow and

disable the patient soon thereafter." Relationship between trauma and syphilis was noted by Cazenave in 1843. In 1877 Tarnowsky proposed a cutaneous test for syphilis by "provocative cauterization;" indolence of healing was taken to indicate lues. In 1918, Lacapère and Laurent commented on the frequency of gumma of the forehead in Mohammedans, from striking the head on the ground in prayer. Medicolegal reports published in the *Journal of the American Medical Association* in 1928, 1931, 1933 and 1937 show compensation awards for activation of syphilis by industrial trauma.

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## OUR STAKE IN WORLD HEALTH

FRANK G. BOUDREAU, M.D., *New York City*

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The Author. *Executive Director, Milbank Memorial Fund*

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## SUMMARY

Comparisons are drawn between the one-fifth of the world's population living in developed areas and the two-thirds who live in the undeveloped countries. The mass diseases of the backward countries are enumerated and the basis for eradicating them established. The methods of rendering aid to backward countries are outlined with the objective in mind of freeing these countries from such diseases as are preventable. World Health Organization is the only international health authority and as such is peculiarly fitted to spearhead this movement.

**D**URING the last fifty years there has been greater progress in science and technology than in the preceding two thousand years. A Rip Van Winkle who had gone to sleep in 1900 would find it hard to believe that he was in the same world today. In particular, the advances in transport and communication have made all the peoples of the world our near neighbors. We are now as close to Africa and Asia as New Yorkers were to Boston and Washington at the time of the Revolution. Our nearness to countries which were formerly remote has made us deeply conscious of the dilemma of our times, the widening gap between the advanced and the backward peoples. All the benefits which science can bestow have been showered on the peoples of the western world, so that they enjoy rising standards

*Presented at the 18th New England Health Institute, University of Connecticut, at Storrs, June 19, 1952*



of living, freedom from most epidemic and mass diseases, and an expectancy of life at birth of over sixty years. The only benefits enjoyed by the backward peoples are the radio and the airplane which bring them news of the luxuries enjoyed by the West while they themselves still live in a world of disease, hunger, and premature death.

The changes which came slowly to our ancestors after the industrial revolution are coming suddenly to the backward countries, giving their peoples little opportunity to adapt themselves to the new conditions. The twentieth century has suddenly overtaken men and women still living in the dark ages. Modern communications are so advanced that the human voice travels around the world with the speed of light. No aspect of western living is hidden from the native in Africa, the peasant in China, the shepherd in the hills of the Near East or the nomad in the desert. It is no wonder that the peoples of the world's underdeveloped countries are on the move, working out their bill of complaints and ready to fight for their share of the benefits which science has brought to the West. The tragedy is that the conditions for which they long cannot be brought about quickly. Our own progress was based upon a foundation of education and of the gradual development of our human and natural resources. Once that foundation was laid, social and economic progress became rapid. Practically no such foundation exists in the backward countries, so that now when we have come to understand that the world cannot exist two-thirds in the middle ages, one-third in the twentieth century, the western world is advancing rapidly and the backward world is virtually standing still.

In the days of the League of Nations and during World War II the community of nations and individual governments made a small beginning to assist the backward countries. These efforts have steadily increased until now they represent major policies of the United Nations, the specialized agencies and a number of governments. In spite of these efforts the disparity in living conditions between the advanced and the backward countries has increased. In *Alice in Wonderland* the White Queen takes Alice by the hand and runs with her as fast as possible, explaining that this is the only way to stay in the same place. In the matter of assisting the underdeveloped countries we have not yet run fast enough to maintain our position.

In this emergency, while long range plans are being made for social and economic development, we can bring immediate comfort and relief to these peoples by helping them to free themselves of the mass diseases which prey upon their health and life, causing underproduction, unemployment and poverty. We talk glibly about industrialization, mechanization of agriculture, education, road building, drainage, and soil conservation, but these cannot be carried out by a sick people so that the prevention of mass diseases is a precondition of social economic progress.

One-fifth of the world's population, about 240 million people, live in the developed areas, comprising Australia, Canada, New Zealand, the U. S. A. and Western Europe. Two-thirds or more than a billion and a half people live in the underdeveloped countries, comprising large parts of Central and South America, nearly all Africa and all Southern Asia. For the mathematically minded let me add that I propose to disregard for tonight the one-sixth of the world's population living in areas which are in a state of transition. The annual per capita income is estimated at \$461 in the developed areas and \$41 in the underdeveloped. In many of the less developed countries the extremes of wealth and poverty are particularly striking, whereas in the more highly developed countries there is a tendency towards greater equality of income.

Food supplies in the developed countries represent an average of three thousand calories per day per person, whereas in backward countries they average only a little over two thousand calories. There is an average of one physician or more per thousand persons in the developed areas and less than one per five thousand persons in the backward countries. In the developed countries life expectancy at birth is 63 years or more, while in the underdeveloped regions it is only 30 years. The terrific wastage of life in such countries as China, Egypt, and India is revealed by the fact that only 54 of every 100 babies born reach the age of 15 years and of these 54 only 15 have any chance of living to 60 years. In marked contrast, 92 of every 100 born in the developed areas reach the age of 15 years and 70 live and produce until they are sixty.

These large differences in the chances of living to a productive age are due mainly to the prevalence in the backward countries of mass diseases which have been conquered or controlled in the West.

The mass diseases include malaria, yaws, bilharziasis, syphilis, tuberculosis, hookworm, and other intestinal parasites, nutritional deficiencies and gastrointestinal infections. In addition, trachoma, smallpox, bubonic plague, cholera, typhus, typhoid and yellow fevers may become mass diseases when circumstances favor their spread.

Malaria is the most prevalent and deadly of all the mass diseases, affecting at least 300 million persons and killing three million a year. These figures fall short of revealing the full extent of the damage caused by malaria, for by its drain on human strength it causes disability, unemployment, reduces food and industrial production, and leads to poverty and backwardness. When refugees from Asia Minor were settled in Greek Macedonia after the Greco-Turkish War, they were given land, houses, tools, farm animals, and seeds. Everything went well until it was time to harvest the crops. Then came an outbreak of malaria which was so malignant and widespread that the farmers could not leave their beds, and the whole effort had to be renewed although it appeared likely that this would only mean a repetition of the tragedy. Syphilis is world-wide but in backward countries, and particularly in the endemic form, may be from forty to seventy-five times as prevalent as in North West Europe. Trachoma prevails widely in the dry dusty tropics, where it is a common cause of blindness and defective vision. Tuberculosis is universal in the backward countries with high death rates such as our ancestors experienced at the beginning of the industrial revolution. Beriberi, rickets, scurvy, osteomalacia and other nutritional deficiency diseases are major causes of mass sickness and deaths, of starvation and poverty in the backward countries. Gastrointestinal diseases of various kinds are responsible for much of the terribly high infant mortality in the backward countries. In many of these regions intestinal parasites are almost universal, adding an extra burden to a sickly people seeking to extract a scanty living from the reluctant soil. The bright spot in this dark picture, which I have sketched for you in merest outline, is that we now have wonderfully effective means of preventing or controlling many of these diseases. Italy, Ceylon and Brazil, Sardinia, Cyprus and Greece have been virtually freed of malaria by residual spraying with DDT at a cost of a few cents per inhabitant. This is indeed a modern miracle, for in some of these countries the history of malaria goes back hundreds of years, and for all those years

it has sapped the health and strength of the people, hindered social and economic progress and kept large tracts of anopheles-infested land out of cultivation. Now at long last the people can sow their crops in the assurance that they will be able to bring in the harvest.

In some countries malaria may be the biggest factor accounting for the wide differences between the sickness and death rates of East and West. In 1947 a program of residual spraying with DDT in Ceylon practically wiped out malaria. The general death rate which had fluctuated between 20 and 25 per thousand fell quickly to between 12 and 15 and has since remained at that level, just about equal to that of Ireland, an island with about the same population in the western world.

That nutritional deficiency diseases can be prevented at a relatively low cost has been demonstrated again and again. The most striking example took place recently in the Philippines in Bataan Province, where in a carefully controlled experiment rice enriched with thiamine was supplied to groups in the population. Both the controls and the experimental groups have been kept under observation for long periods. The results prove that in this ancient stronghold of beriberi the disease can be prevented at a cost of thirty to forty cents per person per year.

You will find many more examples of the disease preventing potentialities of modern medicine in Dr. C.-E. A. Winslow's monograph, *The Cost of Sickness and the Price of Health*.<sup>\*</sup> The point I wish to emphasize is that we have the means and the knowledge to help our fellows in the backward countries to clear away the jungle of evil represented by these mass diseases. This we can do now, and if we fail to do it, we may not succeed in persuading backward peoples that they should join with us in promoting peace and world unity. Nor shall we succeed in assisting them to reach higher levels of living which would help to bridge the widening gap between the two worlds.

When action of this kind is proposed, many obstacles and difficulties loom on the horizon. The spectre of over population is particularly horrifying to many. In the West the decline in mortality began at about the time of the industrial revolution and resulted in a seven fold increase in the population

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<sup>\*</sup>Published by World Health Organization



of Europe and Europe overseas within the space of about three hundred years. In recent years reductions in birth rates began to balance the fall in death rates, and it is probable that the increase of Western peoples will end within a few decades. Having regard to the teeming populations of India, China, and other countries of Asia, the specter of a seven fold increase in numbers is a horrifying one. We have been warned on many occasions that our natural resources are diminishing, and it is natural to assume that were such great increases in world population to take place, the end would be starvation and misery. This argument appeals particularly to the timid who dislike to take positive action. If we look ahead one hundred or two hundred years, the prospects are indeed dismal. But who can foretell what conditions will be like at that time? According to the highest agricultural authorities enough food can be produced to feed all the people of the world in 1960, including plenty of allowance for expected increases, better than they have ever been fed before. If in future the world is not better fed, it will not be because of a shortage of physical resources but because of poverty and ignorance. Those who make gloomy predictions balance what is known about natural resources against population numbers. But natural resources are not fixed quantities, nor are people only consumers. Man himself is our greatest natural resource, for he alone is capable of unlocking new storehouses of energy and other resources. At present the progress of science is based on the education and training of some of the youth in the western world. When opportunities for such training are more widely available, in the now backward countries as well as in the West, science may make much faster progress for there is no reason to believe that western man alone is endowed with the capacity to wrest from nature the secrets she has been holding in trust for mankind. Let me also point out that mass disease is wasteful and uneconomic, causing unemployment, underproduction, and adding to the costs of food and goods. This is a tempting side road, and we could spend several hours exploring it without changing the opinion of the pessimists that reducing mortality in backward countries will lead straight to destruction, or altering the belief of the optimists that it would carry us directly to the land of promise. One more comment I must make: there is everything to be gained by securing and holding the friendship of backward peoples. To deny our help to them in the prevention

of mass diseases because of our fear that their numbers may increase too greatly is no way to make friends and influence people. And we do not need to believe that the lag in the fall of birth rates after mortality begins to decline will be as great as it has been in the past. That would be to deny the ability of mankind to learn by experience, and thus to doom our world to early destruction.

If you have followed me so far, and I fear it has been a tiring journey, you will be ready to consider ways and means. How shall we go about the task of helping backward countries to free themselves from the misery of preventable disease, so that they may begin the long slow journey to higher living standards?

Fortunately the world has acquired sufficient experience in this business to enable it to tackle the whole gigantic task with skill and confidence. Last year was the hundredth anniversary of official international health work. The present World Health Organization with a membership of over eighty governments has inherited all the experience and other assets of the several international health agencies which preceded it. WHO is now the sole international health authority, working closely with the United Nations and the specialized agencies, but independent enough to spearhead the movement for world-wide economic and social development on its own initiative. It is fortunate indeed that the almost miraculous advances in preventive medicine should coincide with the urgent need of the backward countries to be relieved of the heavy burden of disease and death which keeps them in misery and poverty, and with the development of a single international health authority.

The World Health Organization is peculiarly fitted to lead the way in a world revolution which will have as its aim not the destruction of present civilization but the organization of a peaceful world, not the leveling down of all countries to lower standards of living but the raising of the poorer countries to the standards of the most healthy and prosperous. WHO, above all other international agencies, is best fitted to show the way, for its jurisdiction is in one of the few areas where men of all races and creeds can work easily together.

If WHO is to assume this great responsibility, it must be supported much more generously than in the past. Leading doctors and health experts must be willing, nay eager, to work for it, governments

must contribute far more generously than at present to its budget, and the peoples of the world must express their willingness to be taxed for the organization of peace as they have been obliged to contribute for the prevention of potential or actual aggression. Billions have been expended for what corresponds internationally to police forces and police courts. Police action is useful in detecting and punishing the criminal, but building peace in a community, rooting out the causes of crime is a task for other forces.

Everyone who reads the record knows that WHO and FAO, the two specialized agencies dealing with health, have been supported on a most meager scale, far less adequately than governments support city health departments or state departments of agriculture. Without far greater resources these two agencies can never accomplish the tasks for which they were created. What then are we in danger of losing if our support continues on the present inadequate scale?

We may lose the chance to win the friendship of backward peoples and far greater health security for ourselves by cooperating with all other governments in a world-wide campaign against the mass epidemic diseases and the prevalent nutritional deficiencies.

We may lose the chance to take part in building up a great stockpile of knowledge and experience in the maintenance of health and the prevention and treatment of disease. No nation has a monopoly of such knowledge and experience. Chemotherapy came to us from Germany, penicillin from Britain, insulin from Canada, DDT from Switzerland, the electrocardiograph from The Netherlands. Public health and modern medicine have been built up by the contributions of many workers in many lands. The process has been slow, many obstacles have had to be overcome, many unnecessary delays have occurred. These phrases do not sound dramatic but they may mean life or death to thousands. With adequate support WHO will proceed faster with the building up of this international life saving disease preventing stockpile. It will become, in a very real sense, the public health and medical arsenal of the free world.

We may lose the opportunity to cooperate in building up a world-wide united front in the struggle for good health and disease control; an army of health which will guard every sector, making the whole world safer for all peoples, for no people

can be safe while pestilential disease is loose in any country.

We may lose the chance to build peace into the minds of men. Our present age is characterized by aggressiveness and competitiveness. These qualities may have been necessary for survival when food production could not keep pace with population growth, but they are anomalies in the industrial and scientific world of today. Cooperation with other peoples is the key to our survival but aggressiveness and competition persist.

The challenge of the times is to sublimate man's innate aggressiveness into vigorous cooperative action toward building a world society in which opportunities for health, long life, rising standards of living and freedom will be open to men, women, and children of every race, creed, or country. WHO's present limited poorly supported programs for mental health need to be developed and expanded until they cover the earth. Combined with education and other social measures, they may prove to be keys to the solution of our most pressing problem: how to build peace into the minds and hearts of men, how to adapt man's behavior to the conditions and complexities of the new world in which he lives.

We may lose the chance to gain experience in working together for purposes in which all men believe and in which there is no need for competition. For the supply of health is unlimited. If your neighbor's health improves, you also profit. Better health throughout the world is well worth working for but the experience gained in working together may prove in the long run to be of far greater value. For world society in this age cannot exist without some form of world government to facilitate the cooperation of peoples and to restrain the violence of unruly nations. There are those who would do away with the United Nations, substituting therefor a world constitution, a world parliament and a complete apparatus of world government on the model of federal governments in Switzerland or in this country. Unfortunately man learns by slow experience, by trial and error. The pages of history are full of noble experiments which failed: the Kellogg Pact, the Locarno Agreements, the Versailles Treaties and the Charter of the League of Nations. World government is essential, but it must be built gradually, brick by brick, beginning in areas of common interest where cooperation is possible and the results are of benefit to all. The expe-



rience men gain in working together for world health will serve them well when the time comes to tackle more difficult tasks; it will fit them better to be useful citizens in the world of tomorrow.

Much of the criticism levelled at the United Nations and its agencies, much of the United Nations' weakness and a large part of the lack of public knowledge and interest in international co-operation, particularly in technical fields, is due to the fact that governments and not peoples rule the United Nations. In this and other democratic countries, the people have a voice in the conduct of U. N. agencies through their elected representatives. But this is somewhat remote. I do not believe it will be possible for some years to come for the people to elect representatives to sit on international legislative assemblies. But some way must be found to give the people greater interest and more of a voice in the several international agencies. The American Association for the United Nations, successor to the League of Nations Association, is a most useful citizen agency which speaks courageously for the principles of the Charter. This Association has joined with the National Health Council in sponsoring a National Citizens Committee for WHO, a committee which will give all private citizens who care to join it, an opportunity to emphasize the importance of international health and other constructive measures at a time when public attention is concentrated almost exclusively on defense against aggres-

sion. In international affairs the people are often ahead of their political leaders, and I am sure that greater knowledge of the work of such agencies as WHO and FAO would increase people's faith in the possibility of building solid foundations for peace by disease prevention, health promotion, improved nutrition and rising standards of living.

For the almost incredible progress of science in recent years has made it possible at long last to develop all human and natural resources and to raise the standard of living throughout the world to new high levels. Methods are being perfected with which to solve the social, economic, and political problems which at present seem to loom so ominously on the horizon of our future. And scientists mainly from the West, are fashioning tools with which to build a new world of peace, abundance, and progress. When opportunities such as have been available to the West are opened to the men and women of the backward countries, there is every reason to expect more rapid progress than ever before in the history of the world. For in the distribution of talent and genius nature has paid little attention to race, color, or creed. In the exciting days ahead, architects and builders from many lands will work together in shaping the world of the future. In the light of what has been accomplished by a few workers in the recent past, only the gloomiest of pessimists would dare to declare that man's upward progress is slowing to a stop.

# CONNECTICUT STATE MEDICAL SOCIETY

## 162nd ANNUAL MEETING

BULKELEY HIGH SCHOOL, HARTFORD

April 27, 28, 29, 1954

April 27 — House of Delegates

April 28, 29 — General Scientific Program and Section Meetings

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### PROGRAM

Wednesday, April 28

#### General Program

AUDITORIUM OF THE HIGH SCHOOL

9:00 REGISTRATION

9:15 MOTION PICTURE FILM

9:30 CALL TO ORDER—President of the Society  
ADDRESS OF WELCOME—President of the Hartford County Medical Association

10:00 MEDICAL MANGEMENT OF HYPERTENSION  
Henry A. Schroeder, *St. Louis, Missouri*

10:35 DIAGNOSIS OF CHEST DISEASES  
Edward J. Welch, *Brookline, Massachusetts*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

11:45 SUDDEN DEATH  
Lester Adelson, *Cleveland, Ohio*

12:20 CLINICAL APPLICATION OF RADIOISOTOPES  
Lee E. Farr, *Brookhaven National Laboratory, Long Island*

1:00 LUNCHEON, Cafeteria of the High School

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2:00 PROGRAM BY HARTFORD HOSPITAL  
Historical and Clinical Meeting Commemorative of the Founding of the Hartford Hospital—  
1853

3:30 SECTION MEETINGS



## PROGRAM

Wednesday, April 28

Room 169

- 10:00 HEMORRHAGE, A FOREMOST PROBLEM IN OBSTETRICS  
Duncan E. Reid, *Boston, Massachusetts*
- 10:45 TRANSFUSION REACTIONS  
Alan Richardson Jones, *Boston, Massachusetts*  
Discussion opened by Daphne Richardson Jones, *Boston, Massachusetts*
- 11:30 INTERMISSION TO VISIT EXHIBITS
- 12:00 ACUTE RENAL SHUTDOWN AND THE ARTIFICIAL KIDNEY  
Roy C. Swan, *New York, New York*
- 1:00 LUNCH AND VISIT TO EXHIBITS
- 3:30 SECTION MEETINGS
- 

## PROGRAM

Thursday, April 29

General Program

AUDITORIUM OF THE HIGH SCHOOL

- 9:00 REGISTRATION
- 9:15 MOTION PICTURE FILM
- 10:00 RECURRENT INTESTINAL OBSTRUCTION  
Victor P. Satinsky, *Philadelphia, Pennsylvania*
- 10:35 EVALUATION OF THE DEEP VEINS FOLLOWING THROMBOPHLEBITIS  
Josephus C. Luke, *Montreal, Canada*
- 11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS
- 11:45 CARDIAC ARREST  
Hugh E. Stpehenson, Jr., *Columbia, Missouri*
- 12:20 SURGICAL TREATMENT OF CORONARY INSUFFICIENCY  
Arthur M. Vineberg, *Montreal, Canada*
- 1:00 LUNCHEON, Cafeteria of the High School
- 
- 2:00 DISEASES OF THE BILIARY TRACT  
Program arranged by Connecticut Society of American Board Surgeons
- 3:30 SECTION MEETINGS

## PROGRAM

Thursday, April 29

ROOM 169

- 10:00 PLASTIC AND RECONSTRUCTIVE SURGERY  
Richard H. Walden, M.D., D.D.S. *Hempstead, New York*
- 10:45 THE CONTRIBUTION OF THE ORAL SURGEON  
Daniel J. Holland, Jr., D.D.S., *Boston, Massachusetts*
- 11:30 INTERMISSION TO VISIT EXHIBITS
- 12:00 THE TREATMENT OF SPEECH DEFECTS FOLLOWING SURGERY  
G. Paul Moore, PH.D., *Evanston, Illinois*
- 1:00 LUNCH AND VISIT TO EXHIBITS
- 

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THE CONNECTICUT STATE MEDICAL JOURNAL



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### JOSEPH H. HOWARD — SAMUEL C. HARVEY

One hundred and twenty physicians have been presidents of the State Medical Society through its long and fruitful life. These men, selected by their colleagues to be briefly the titular head of the medical profession in Connecticut, have served well and have shaped in unknown and forgotten ways the course of our destiny.

Two presidents of the Society, Joseph H. Howard, 1945-1946 and Samuel C. Harvey, 1948-1949, have lately departed from our midst and we mourn their loss. They had served the Society in the finest tradition, each in his own splendid way. Dr. Howard was a superior clinician with a broad interest in people, their social thinking and their welfare. These characteristics made him especially valuable to the Society and he gave it generously of his time.

Dr. Harvey was an eminent teacher of surgery and from his long training in medical science he brought to the Society the highest ideals, intelligence and judgment. He had received many honors but none which brought him more satisfaction than the presidency of this Society.

It is from men like these that the Society gains the leadership and wisdom that has made it strong and as they pass into the bright regions of our history we express our profound respect and warm esteem for their fellowship with us.

A RESOLUTION FROM THE HOUSE OF DELEGATES DECEMBER 10, 1953 PREPARED BY A SPECIAL COMMITTEE, EDWARD J. WHALEN, CHAIRMAN, FRANKLIN S. DUBOIS, AND CHARLES T. FLYNN, SR.

### The Great Experiment

Beginning February 8 in the South and extending gradually into other areas the National Foundation for Infantile Paralysis will carry out a vast \$7½ million program of inoculation against polio with the new Salk vaccine. The Foundation is now in the process of injecting 5 to 10,000 human beings in Allegheny County where 700 have already been vaccinated without any untoward effect. Although this project constitutes a great experiment, the Special Advisory Committee on Active Immunization of the Foundation has satisfied itself that the

vaccine is safe and ready for field trial. It is planned to terminate this project by June 1, 1954.

The new vaccine was developed by Dr. Jonas E. Salk of Pittsburgh. The procedure for destroying virus infectivity has satisfied both the originator of the vaccine and the special committee. The final determination of the destruction of infectivity is further tested by intracerebral inoculation of monkeys, tissue culture with blind passage of subcultures, and tests for sterility as recommended by the Laboratory of Biologics Control of the National Institute of Health. This procedure for destruction

of infectivity of the virus, as well as the above safety tests, will be carried out on each lot of vaccine prepared for use for human vaccination. The manufacturer, Dr. Salk's laboratory and the Laboratory of the National Institutes of Health will each independently test each lot of vaccine for safety as well as for sterility.

The experiment is to be carried out on second grade school children because this group shows the lowest naturally occurring antibodies and a high specific attack rate. Children in the first and third grades will be used as noninjected vaccine group controls. All the vaccinations will be carried out in the schools and no child will be vaccinated unless a signed request is received from a parent.

The entire program is under the Medical Department of the Foundation and will be effected through the various State Departments of Health. Licensed local physicians will contribute their services in administering the vaccine. They will be assisted on a volunteer basis by local nurses, local health directors, teachers, and members of the county chapters of the Foundation. The Foundation will supply the vaccine without cost. The first two inoculations will be given one week apart and the third or booster inoculation will be given at least four weeks after the second. The follow-up program will be conducted by local physicians. It is anticipated that protection will be effective over about the same length of time as in the case of smallpox vaccine and diphtheria inoculations.

Certain areas in certain states will be selected for this experiment. As yet these have not been determined, at least in Connecticut. The total deaths and the rate per 100,000 population for polio in Connecticut from 1948 through November 30, 1953 shows some interesting facts. Fairfield County had the greatest number of deaths, about one-third more than Hartford County and more than three times New Haven County. For the paralytic cases, 1951-1953 (November 30 inclusive), Fairfield County had 60 per cent in 1951, 64 per cent in 1952, and 44 per cent in 1953. For the same years Hartford County had 21 per cent, 34 per cent, and 30 per cent, and New Haven County 53 per cent, 62 per cent, and 53 per cent, respectively.

The medical profession as well as the public will watch this great experiment with interest. Connecticut will be entered some time in the spring. Those areas selected for the trial may consider themselves

fortunate as this is the first great field trial of a poliomyelitis vaccine and is expected to replace gamma globulin which is not a vaccine and afforded protection for only a short period of time.

### Let's Stop and Think

It is probable that a broad and completely satisfactory understanding of the changing pattern of hospital-physician relationships may never be reached. The subject has been a matter of debate in each successive meeting of the AMA House of Delegates for several years but it does not seem much more clear than when it started. There were a number of resolutions on the problem introduced at the St. Louis meeting and with finesse the Reference Committee on Miscellaneous Business answered them all with a resolution that the "Guides for Conduct of Physicians in Relationship with Institutions be strictly followed." These "Guides for Conduct" gracefully leave many important things unsaid and only help a little in clarifying the issue.

There has been one statement on the subject that impresses us as being logical and worthy of further contemplation. We refer to the "President's Page" of Dr. Edward T. Wentworth, then president of the Medical Society of the State of New York and published in the *New York State Journal of Medicine* for October 1, 1952. It is not to be assumed that Dr. Wentworth's comments reflect the general opinion of the physicians of the State of New York but they are thoughtful and reasonable. We shall quote them freely.

Dr. Wentworth said "The physician is only one part of the medical-social whole. He cannot alone determine his destiny. He is confronted on all sides by groups intent upon some objective, usually a worthy social one, which involves shifting of physicians from individual private practice to a position of being retained by some agency rather than by individual patients."

"One such agency, and certainly the last one which would do the physician any harm, is the hospital, particularly the hospital which is an integral part of a medical school. Nevertheless, there are a great many complaints being voiced by physicians that these agencies are 'practicing medicine' and thereby interfering with the normal economic progress of those physicians who practice in the immediate vicinity of such institutions."



"The physician who is really dedicated to his professional work profits economically by working in the vicinity of a medical school or a hospital because of the remarkable opportunities furnished him by those institutions, whether he is officially connected with them or not, constantly to improve his diagnostic and therapeutic technics and to acquire a sound philosophic point of view of his mission in life. It would be a great mistake not to recognize and evaluate these positive values in any consideration of hospital professional relations."

"What is feared is the power inherent in the law which places full responsibility for hospital policy and management in the hands of boards of directors which see to it that, with astonishingly few exceptions, there are no doctors on the board. It is not lay control of, or even intervention in professional decisions that is feared but replacement of private practice with its individual business relationships between doctors and patients by hospital-controlled distribution of medical care. We are assured by board members and hospital administrators that they have no thought of expanding their chartered function to care for the sick, to the extent of control of medical practice. It seems almost ridiculous to think that hospital boards would want to take on any such responsibility, but is it not equally ridiculous for a lay group to have complete control of a professional institution? The practitioner's fear of the inherent tendency on the part of any agency to expand its power, a tendency often quite unstudied by the individuals concerned, is natural and excusable."

"The practitioner is apt to look upon institutional specialists as the beginnings of such an aggrandizement by hospitals which, if carried through to its possible end, might be little different from socialized medicine, except insofar as the individuals on hospital boards might well be less actuated by power motives than are some politicians. The experienced private practitioner more than the neophyte is aware of the value to the public of retention of individual private practice. At present he is so sensitized to the evils inherent in mass control of practice that he is somewhat blind to the advantages inherent in full-time hospital practice by laboratory specialists. He recognizes that such practice makes for efficiency and better medical care to the hospital patient, but he fears that it is the entering wedge of a system to include clinical care both inside and outside of the hospital."

"In this discussion the word 'exploitation' will frequently be used. It will be used in its economic sense of depriving an individual of something he has earned. The word 'profit' will be used in the meaning of excess of income over expenses involved in getting that income. Voluntary hospitals do not make a profit. If ever they get out of the red for any extended period they must reduce charges. They are chartered by the state as nonprofit membership corporations to care for the sick, which includes the training of individuals to carry out that function. The hospital has to look at all of its work as a service to humanity. Some parts of that service are better than self supporting. Some parts are entirely dependent upon outside support. Some enjoy limited income but have expenses in excess of receipts. All of these services are inextricably interwoven to make up the institution's humanitarian service.

"It is not reasonable to conclude that to prevent exploitation of hospital specialists each department must be run on a balanced budget. There are other ways to prevent exploitation. In industry and merchandising some departments are run at a loss and carried along by other profit-making departments. We do not think of those working in the profit-making departments as being exploited. Where the end product is humanitarian service, where there is no such thing as monetary profit to any individual, how can one conclude that, if one department which can make money helps out another department which cannot meet expenses, always those working in financially successful departments are being exploited?

"In the first place profit alone is not synonymous with exploitation. Industry employs salaried physicians to run its medical bureaus because it is profitable. The profit lies in time spent by employees going to the doctor, profit involved in hiring doctors and nurses on a salary basis for less than it costs in fees to individual practitioners, profit in employee satisfaction in his employment because of the many little medical advices and services rendered by the company doctors—services which do not come under the compensation law, services for which the employee pays nothing in time or money. Such services are really a part of the employee's wages. Hospital and medical care has been held by the courts to be part of wages, properly subjected to collective bargaining by unions and employers. If there were no profit in it industry would not be hiring doctors.

Medicine has accepted such hidden profits as proper and says nothing about exploitation of doctors who make such profits possible. It is hard to see how profit alone constitutes exploitation.

"The profit to industry made by physicians working on a salary constitutes a small by-product in that health service is not the real business of industry, health service is not what industry sells. Nevertheless, profit obtained from what the industry does make or sell is dependent to a very large degree upon the efficiency of employed personnel whose wages constitute the largest factor in costs. Health of the wage earner can easily be considered as a very important part of the real business of any industry.

"If one attempts to eliminate all profit to the hospital from a successful department some very embarrassing situations arise. If the head of a hospital department receives all of the fees from patients, he could and sometimes does underpay his staff and keep for himself an income entirely out of proportion to that possible to any fellow specialist who does not enjoy his noncompetitive position. It is an inescapable fact that the hospital specialist enjoys a pre-established practice which is conducted on a mass basis."

"If, to eliminate departmental profit, the fees to patients are reduced to a balanced budget level, so much of the work of a community would be done in the hospital that the private practitioner would really be in economic trouble. Hospital fees and outside fees for laboratory services have to be about the same. We all need the services of these hospital specialists for our hospital patients. It is such a convenience to be able to go over with the specialist the conditions of our in-hospital and outside patients at one place and time that attempts to show the practitioner the wisdom of supporting the private practitioner rather than the hospital specialist have to be made over and over and without complete success. If the fees for services in hospital where work is done on a mass basis were reduced as low as they could be without financial loss in the department, no progress whatever could be made toward gaining support for the outside practitioner.

"To limit the profit which is possible to an individual who enjoys a monopoly provided by virtue of his working in a noncompetitive position on a mass production basis can hardly be called exploita-

tion. In fact, to give him all of that profit means that he isn't paying anything for his monopoly. This must not be construed as argument against investigation and correction of conditions where hospitals do exploit institutional specialists for financial profit. Profit alone, however, does not constitute exploitation, a condition which can hardly be defined in general terms."

"There is danger that the specialist limited to hospital work may lose his independence to the authority of governing boards and administrators if he sells his services to them rather than to individuals receiving them. It is necessary for the profession to fight that tendency, but it is an economic battle rather than an application of ethical principle. It is a battle to be fought where exploitation exists rather than by an ethical attack upon all hospital specialists, many of whom are entirely happy about their working arrangements, and some of whom for a multiplicity of minor reasons, chiefly personality defects, don't get along well with either the staff or the administration."

Finally President Wentworth said so clearly that we could all agree with the observation: "Wherever a physician working for a voluntary hospital thinks he is being exploited, let us go to work with the system outlined in the 'Guides for Conduct of Physicians in Relationships with Institutions,' published by the AMA in December, 1951. Let us ascertain if he is being exploited and, if so, do our utmost to correct that situation. But let us not expect governing boards or the public to see any determining force in a statement that 'A physician should not dispose of his professional attainments or services to any hospital . . . under terms or conditions which permit the sale of the services of that physician by such an agency for a fee' 'because it is unethical' and 'beneath professional dignity.' Let us attack with a reasonableness which enables us to discern the differences inherent in individual practitioners and existing in different communities rather than by the universality of the closed shop method which fails to recognize the only finite source of social progress—freedom to exercise individual imagination and intelligence. Let us not deny every hospital specialist an ethical standing in medicine just because he works for a hospital which collects fees for his services rendered."



## The Yale Diagnostic Clinic

There is satisfaction in noting the renaissance of the Yale Diagnostic Clinic as announced by the sprightly folder distributed to physicians recently. This Clinic was under consideration in the Council of the Society and the Committee on Cooperation with the Yale School of Medicine for a long time. The details of its operation were carefully planned so that it would be a consultative clinic only, would not accept patients unless referred by private physicians, and after the diagnostic study had been completed would provide the referring physician with a full report of the findings and return the patient for treatment.

When the proposal was first discussed with physicians there was some criticism from a few sources who were fearful of competition with private practice, but in general there was agreement that such a clinic would be a valuable addition to the medical care facilities in the State. After more planning and joint effort by the Committee on Cooperation with Yale, the Clinic was opened in 1948.

Use and popularity of the Clinic grew slowly at first, but fairly steadily. After the first little booklet announcement no means of promotion were used. Many physicians never learned about it or forgot it and it never became a vigorous and vital project. A good deal of the investigation was done by residents and the lack of participation of staff experts was felt. Comments were also heard that reports to physicians were delayed and sometimes inadequate. Where the trouble lay was not apparent to an outside observer, perhaps there was no trouble, maybe it slowed up because it did not have business enough to give it momentum.

Now comes the bright, new announcement which states the policy of the Clinic and the State Society reaffirms its interest in it and its hope that it will open a new era of usefulness to the physicians and people of Connecticut.

"The facilities of the Diagnostic Clinic are available to any licensed physician for the study of diagnostic problems of adults and children. It is the policy of the Clinic to make it possible for each physician of the State to obtain for his patient the most complete diagnostic service that can be made available without interfering with the relationship between the patient and his referring physician. No patient is seen unless referred by a physician. The

closest possible cooperation between referring physician and Clinic staff is encouraged. All correspondence is with the referring physician and subsequent visits are arranged only through him. The referring physician maintains, at all times, complete control over the disposition of the case."

## Justice

*"Justice, sir, is the great interest of man on earth."*

*Daniel Webster*

The words of Daniel Webster quoted above should be as applicable today as they were the day that great champion of human rights uttered them. Yet we find one of our nonprofit hospitals, an institution which was organized under the aegis of our State Medical Society and for the realization of which our Society emptied its coffers in 1820, gradually being taxed dangerously near bankruptcy.

The annual report of the Institute of Living for 1952-1953 is startling. Would that it might startle the city fathers who have been extracting from its coffers over \$100,000 annually since 1943. Examine these figures!

"Operations for the current year resulted in a loss of \$83,837.55 before application of income of \$57,026.67 from investments and from other sources, and of \$17,233.12 received under government research contracts," a net loss of \$9,577.76.

TABLE I

YEAR 1952-1953

Gross operating loss.....	\$83,837.55
Income from investments and other sources .....	\$57,026.67
Income from Federal Government for research .....	17,233.12
	<hr/> 74,259.79
Net operating loss.....	\$ 9,577.76

"During the current fiscal year the hospital provided 127,738 patient days, of which approximately one-fourth were for Connecticut residents. Sixty-nine per cent of the total patient days . . . were provided on a less than cost basis. Of this figure, 1,619 patient days were provided at no charge whatever.

"While 69 per cent of all patient days were on a less than cost basis, it is of particular interest that 85 per cent of the 30,365 Connecticut patient days were provided on a less than cost basis. Of this figure,

1,105 patient days were provided to Connecticut patients at no charge."

TABLE 2

TOTAL PATIENT DAYS	CONNECTICUT PATIENT DAYS	TOTAL PATIENT DAYS PROVIDED AT LESS THAN COST	TOTAL PATIENT DAYS PROVIDED FREE	CONNECTICUT PATIENT DAYS PROVIDED AT LESS THAN COST	CONNECTICUT PATIENT DAYS PROVIDED FREE
127,738	30,365	88,139	1,619	25,810	1,105

And in the present year the Institute is experiencing higher costs due to the 40 hour week; hospitalization, insurance and pension plans; and a continuation of the intensive maintenance program.

The Institute has been able to accumulate only \$3 million in its Foundation Funds since it was established over 130 years ago. Much of its construction is old and must be replaced sooner or later if it is to continue to carry on as a first class psychiatric institution. This must mean but one thing, viz., a fund raising campaign to which the public will be asked to contribute in return for the annual \$100,000 bite now taken in the name of taxation.

The controversy which has waged for 10 years and since 1946 has become increasingly acute seems to be based on two things, an ignorance of the true facts, and a widespread reluctance to face the problem of mental illness and its treatment. The facts speak for themselves; there is no profit being realized. The reluctance to properly appraise the problem of mental illness is the more regrettable in this day when modern psychiatry has so much more to offer than it did a generation ago.

Connecticut should be proud it its first mental hospital and Hartford should realize that it too has an obligation.

## Foods, Drugs and Cosmetic Committee

This committee met on September 24, 1953.

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William H. Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Malcolm K. Buck-

ley, patent attorney of Buffalo, N. Y.; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

### ACTION ON ORTHO FLY KILLER

At its meeting on September 24, 1953 the Connecticut Committee on Foods, Drugs, Cosmetics and Devices voted to recommend to the State Department of Health that the sale of "Ortho Fly Killer" be either terminated or carefully regulated. Dr. Bonnycastle, reporting for a subcommittee appointed to study the promiscuous public sale of this substance, stated that the anticholinesterase activity of tetraethyl pyrophosphate was 300 times that of parathion, but the compound was half hydrolyzed in 8 hours at pH 7, whereas parathion remained undecomposed for 120 days. He said that the LD 50 was 2 mg. per kg., and cited an article in the *Journal of the American Medical Association*, 149, 1015 (July 12, 1952). It was highly dangerous material to be allowed to be used promiscuously, and the warning statement on the label of "Ortho Fly Killer" was very inconspicuous. The subcommittee recommended that the Food and Drug Commission take action to restrict the sale of this product.

### HELENA RUBENSTEIN'S SKIN SERUM A DRUG

The Committee went on record as labelling Helena Rubenstein's Skin Serum a drug, since it had found that certain claims implied in the advertising of this product were unsubstantiated by any evidence available to the Committee. These claims made the Skin Serum a drug.

### SEXTROL CONDEMNED

The Committee considered a product known as Sextrol produced by Labco Pharmacal Company, Beverly Hills, California.

Sextrol was described as "a remarkable new discovery in the field of sexology," and its composition and uses were defined as follows: "A scientifically prepared ointment, which when applied to the male sex organ will effectively prevent premature ejaculation, and will permit its user to maintain an erection for one to two hours when performing the sex act." Prof. Fenney said that Sextrol had been circularized to every druggist in the State, a sample tube being offered for \$5.

It was voted that it be the opinion of the Committee that: (1), the description of the material was such as to make it a new drug; (2), no evidence was given to substantiate the claims for it; and (3), it should not therefore be sold in the State.



## PROGRESS IN CLINICAL MEDICINE

### IMMUNIZATION AGAINST POLIOMYELITIS: ITS PRESENT STATUS

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ARTIFICIAL immunization against poliomyelitis has been the target towards which research workers in this field have been aiming for well over forty years. During this period a number of attempts at active immunization in man were tried in this country, notably in 1935, when two groups of workers injected several thousands of children during the poliomyelitis season, with suspensions of infected monkey cord in which the virus of poliomyelitis had been inactivated by formalin, or other chemicals. These tests were made at a time when there was limited appreciation of the fact that there was more than one immunological type of poliomyelitis virus. For this and other reasons it is not surprising that this "first trial" was unsatisfactory, although several thousands of children were inoculated before the unsatisfactory features came to light.<sup>1</sup> The 1935 experiments were quickly terminated when certain accidents, which to this day have not been adequately explained, occurred, and this unfortunate circumstance seems to have set the clock back for at least 15 years in the progress of immunization against poliomyelitis.

As Sabin<sup>2</sup> has aptly said: the goal which the virologist has set for himself today in this disease is to find a practical and safe process to produce artificially what nature does for 99 or 99.9 per cent of the population, and to do this without incurring the 1:100, or 1:1000 risk of paralysis, which is the price paid for acquiring immunity to poliomyelitis naturally. There are several approaches to this end, but the main ones are: (i) passive immunization by injecting specific antibodies; and (ii) active immunization by injecting a substance which will induce specific antibodies in the vaccinated person.

#### PASSIVE IMMUNIZATION

Improved methods have taken advantage of the fact that antibodies against all three of the known

types of poliomyelitis virus, as well as against many other infectious agents, are concentrated in the gamma globulin fraction of pooled adult human plasma. Experiments in monkeys had already shown that if this gamma globulin was given before exposure to poliomyelitis, paralysis might be prevented. From these experiments it appeared that a low level of circulating antibodies might be sufficient to confer such protection, and it was on this basis, together with regard for the protective effect of gamma globulin in measles and infectious hepatitis, that Hammon and his collaborators<sup>3</sup> carried out in 1951 and '52, a large scale trial of gamma globulin as a prophylactic measure against poliomyelitis in more than 25,000 children during the epidemic seasons of those years. The results recorded no serious accidents and very few bad reactions, and indicated that gamma globulin appeared to afford protection against the paralytic disease over a period of 2 to 5 weeks. Only partial, if any, protection was demonstrated during the week immediately following the inoculation; and no protection 6 weeks or later. On the basis of this experience and with the full realization that gamma globulin was not a very efficient agent for the wholesale prophylaxis of poliomyelitis, the use of the rationed supply was widespread in this country during the summer season of 1953. The particular indications for its use in the prophylaxis of poliomyelitis were in household and intimate contacts of clinically diagnosed cases; patients in a hospital ward, or children in a nursery school, or in institutions or camps, following recognition of a case of poliomyelitis; or in individuals coming from uninfected areas into infected homes or institutions; and finally within epidemic areas where the risk to the juvenile population was high. The results of this 1953 experience in this country have not as yet been completely evaluated; nor will they be easy to evaluate. Nevertheless, preliminary indications are that the course of epidemics was not altered in areas where mass prophylaxis with gamma globulin was attempted. All of the available

data will be considered by an Advisory Committee of the U. S. Public Health Service.<sup>5</sup> It hardly needs to be pointed out that the use of gamma globulin as a prophylactic measure in poliomyelitis is still in its infancy, and only after several more years of experience will it be possible to estimate its value and its place in the control of poliomyelitis and the best methods of using the available supplies.

#### ACTIVE IMMUNIZATION

Whereas with passive immunization the susceptible child can only expect temporary protection, considerable expectations for a longer period of immunity might be placed on active immunization against poliomyelitis through the use of vaccines. The trend of research here has been directed towards the preparation of two different types of vaccines, one containing inactivated or killed material obtained from each of the three antigenic types of viruses, either with or without adjuvants; and the other containing live but avirulent strains of virus, again of the three antigenic types. With the latter it might be possible to administer a virus which would produce a harmless though immunizing infection, thus duplicating the mechanism of natural infection and following the lead established long ago by Jenner in the prevention of smallpox, and later by Rockefeller Foundation workers in the prevention of yellow fever by inoculating a harmless variant of yellow fever virus. The situation is triply complicated in poliomyelitis, however, because there are three different immunologic types, and three avirulent variants would be required.

As for the killed material, to date the experiments in animals and a limited but significant number of tests in man have shown that such material derived from all three types of poliomyelitis viruses have induced the formation of type specific antibodies in both monkey and man, and, at least in the monkey, a postvaccinal resistance to infection with the homologous challenged virus is regularly produced. This has been a great step forward, carrying with it at long last the possibility that poliomyelitis vaccines may actually become available to the health officer and to practicing physicians in the not too distant future. But the final and crucial tests on the safety and efficacy of this trivalent immunizing material are yet to be done. They obviously cannot rest on experiments made on mice and monkeys alone but must be carried out on large numbers, in fact very

large numbers, of children before a proper evaluation can be made. It is such an experiment as this that is proposed to be carried out in the United States under the auspices of the National Foundation for Infantile Paralysis during the first half of 1954.

But before listing the possibilities as to how such an experiment could be carried out, it is equally important to list the recent developments which have come step by step in the long up-hill struggle to produce such an immunizing agent or agents, and have thus made "a vaccine experiment" possible. First on the list of these developments stands the demonstration in 1949, by Enders, Weller, and Robbins<sup>6</sup> that poliomyelitis viruses not only multiply in tissue cultures but also produce a characteristic cytopathogenic change by which the presence of virus can be recognized. This has eliminated in large measure the necessity of resorting to the expensive and complicated procedures involved in the use of monkeys, and has served as an invaluable source of virus propagated in a medium which presumably is not as dangerous an inoculum as is nervous tissue. Two additional experimental observations have also made the outlook for artificial immunization against poliomyelitis in man more hopeful: one is the demonstration by Bodian<sup>7</sup> that the amount of antibody required to protect cynomolgus monkeys against paralytic infection experimentally acquired by the intramuscular or oral routes is much smaller than that needed to protect against infection by the direct intracerebral route. The other is based on the study of Freund,<sup>8</sup> indicating that certain adjuvants, made from oily substances or from mycobacteria, can enhance the immune response of a variety of antigens including those of poliomyelitis viruses.

Salk and his associates, utilizing a very extensive experience in their studies of formalinized vaccines against influenza, have turned to the inactivation of poliomyelitis virus by formalin and have reported in detail the results of their first tests with "killed" tissue culture virus vaccines in human beings.<sup>9</sup> Much of the most recent work has not yet been published, but in one series of experiments it appears that antibodies to all three immunologic types were induced by inoculation of small quantities of a trivalent vaccine. It was clear that the post-inoculation antibody response was far greater in those children who had pre-existing type specific antibody to one or more types than in those who were without pre-



existing antibody. This general type of inoculum will probably be the material used on a trial basis in 1954.

At this point, however, it may be well to consider some of the requirements for an acceptable "killed" poliomyelitis virus vaccine and what the potential dangers might be. One should recall that the task is not that of vaccinating against poliomyelitis infections in general, but against paralytic poliomyelitis. The chances of any child or young adult in the U. S. acquiring paralytic poliomyelitis today are a good deal less than 1 in 100 or 1 in 500, but there is no practical way of determining who are the most susceptible children and so, as with smallpox, the entire juvenile population would theoretically require vaccination. Obviously it is essential, therefore, that the risk of serious or other accidents occurring as a direct or indirect effect of the vaccination should be far less than 1 in a 1000. Consequently and primarily a successful poliomyelitis vaccine must first of all be safe, and secondly it must be capable of producing a good degree of immunity against Type 1 poliomyelitis virus, which is by far the commonest type, and immunity against the other two types is also probably essential. To meet the first criterion the vaccine must not only not produce poliomyelitis in the occasionally injected child, but it must not be a potential source of another pathogenic agent, which is more difficult to inactivate than poliomyelitis virus, such as for instance, hepatitis virus. Furthermore, as the "vaccine" may contain some foreign protein and as multiple and spaced inoculations will undoubtedly be necessary, the material must not give rise to anaphylactic reactions or organ damage. This latter is more than a theoretical consideration, for one of the methods of propagating poliomyelitis virus is that of growing it in tissue cultures consisting of monkey kidney cells. It is obviously highly important to be assured, therefore, that the injection of extracts of this foreign protein along with the "killed" virus will have no nephrotoxic action. The report of Freund and his associates,<sup>10</sup> that extracts of testicle injected with oily adjuvants and mycobacteria can lead to degeneration of the testicles of the inoculated animals, emphasizes that an immense amount of clinical investigation is indicated on this point. Furthermore, an important question still to be answered is, whether or not the postvaccinal "immunity" would be permanent or relatively short lived. In other words, the duration of artificial immunity induced by a "killed"

virus vaccine might conceivably be weak and short; it might be enhanced from time to time naturally, by "booster infections" if the vaccinee was exposed to poliomyelitis viruses from time to time, but as yet no one knows for how long such artificial immunity may persist. The point is that poliomyelitis is usually a more severe disease when acquired by adults as compared to young children, and one would like to know, as soon as possible, whether a single or multiple course of active immunizations with a "killed" virus would merely postpone and not eliminate infection. If the infection is merely postponed, then immunization might even have to be repeated periodically for the rest of a person's life! Another important feature of any trial of such material is that it would be better not to carry it out during the poliomyelitis season, and particularly during epidemics. Observations within the past four years have indicated that the inoculation of certain vaccines during poliomyelitis epidemics may precipitate paralysis in an exposed individual. For this reason winter and early spring are perhaps optimal months in which experimental trials can be conducted as far as the State of Connecticut is concerned. It is clear that these and other questions will be considered seriously by those in authority of any forthcoming trials.

As to another possible approach to the task of active immunization, and one which, if successful, would simplify the problem of vaccination and eliminate some of the above mentioned dangers, is the proposition of using not a killed vaccine but a live though avirulent virus, such as is used in vaccination against smallpox or in yellow fever. Under these circumstances, strains of poliomyelitis virus of all three types would have to be discovered or produced, all of which would have permanently lost their power to give rise to paralysis, and yet have retained their power to immunize. The observations of Koprowski and his associates<sup>11</sup> have pointed the way here. His strain of Type 2 poliomyelitis virus, which after passage through cotton rats lost much of its virulence on intracerebral injections in monkeys, produced antibodies in high titer after feeding a single dose to two groups of children. Cabasso and his associates<sup>12</sup> used the same principle in adapting another Type 2 poliomyelitis strain to chick embryos. Another group of workers, Enders, Weller, and Robbins<sup>13</sup> have reported that Type 1 (Brunhilde) strain of poliomyelitis virus after serial passage in tissue cultures lost most but not all

of its capacity to produce paralysis in intracerebrally inoculated monkeys. Studies carried on in at least two other laboratories have confirmed the latter fact, namely, that this tissue culture attenuation has promise in giving rise to variant strains which ultimately might be used for human vaccination. It would appear, however, that no series of completely avirulent strains of poliomyelitis virus are available for any large scale trial in humans at present.

In summary, therefore, it would seem that there really is enough information and experience collected on this problem of active immunization as a method of controlling poliomyelitis to warrant further and extensive human experiment. The experiment is one in which the stakes are high and in which one is justified in taking a calculated risk. The prevention of poliomyelitis on a large scale, if accomplished, would indeed be worth a small number of untoward side effects. An important thing, however, is that all concerned with recommending the experiment or participating in it or carrying it out should be as aware as possible of the fact that it is an experiment. In other words, in spite of whatever lay impressions may have been gained from radio and newspaper publicity, there is no "vaccine" against poliomyelitis as yet. There are a number of substances prepared in a number of laboratories, one of which is now available for trial to see whether as a result of these trials it is going to be proven worthy of the name of vaccine. Before any of these substances qualifies as a vaccine there are at least two distinct questions, repeatedly mentioned above, on which answers will be sought; and it is believed that they will be sought sequentially. The first is, whether or not all lots of the given material are reasonably safe; the second is, whether all lots will actually prevent or modify, or postpone paralytic poliomyelitis or other forms of poliomyelitis. From Salk's published<sup>9</sup> and unpublished results based on observations in several hundred children it appears that the tested lots of material are reasonably safe; and from other information it appears that multiple safety tests will be made by three different laboratories on all new lots of the material. It remains, therefore, for the present hundreds of injectees to be expanded cautiously to several thousand for purposes of safety alone. The final answer to the second question should, logically, not be sought until such time as the first is in hand. Actually hundreds of thousands of injected children will be required to determine statistically over the years whether the age incidence

of clinical or paralytic poliomyelitis is reduced in the vaccinees as compared with suitable control groups; and if reduced, for how long.

It may be trite to add that in any large scale experiment of this type in which a private agency, national, state, and local public health officials as well as practitioners of medicine and pediatricians participate, the shifting of responsibility is easy. But in spite of the clamor and pressure from the radio and the public press which is apt to claim victory before the battle is engaged, the proposed trial should and no doubt will be conducted as a scientific experiment, albeit a bold one, but with all the care and judgment that physicians and medical scientists worthy of the name are expected to use.

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### Obesity Not the Only Answer

Ancel Keys of the Minnesota School of Public Health at the annual meeting of the American Public Health Association last November challenged the accepted premise that obesity is a primary cause of heart disease. Unless the obesity is extreme Professor Keys says it is not a primary cause.

Citing studies made on young soldiers, he challenged the insurance company statistics, upon which the conclusion that overweight leads to heart attacks has been based. He said that the studies revealed that there was no significant difference in weight between the soldiers who died of heart ailments and those who did not. He said that the problem of degenerative heart diseases will not be solved by reduction of body weight alone.

### AMA Past President Edward H. Cary Dies

American medicine lost a dynamic personality in the passing of Dr. Edward H. Cary, 81, in Dallas on December 10. President of the AMA in 1932-33 and a member of the Board of Trustees from 1925-29, Dr. Cary contributed his mature judgment in the House of Delegates as late as 1951.

While serving as president-elect and president of the AMA, Dr. Cary traveled far and wide in behalf of medicine's fight against socialized medicine. As chairman of the executive board of the old National Physicians' Committee, he was one of the pioneers in that battle.

### Connecticut Forms First Society of Gerontology

About 60 people met in Hartford in November 1953 and formed the first State Society of Gerontology in the United States.

The aims and objectives of this society are "to stimulate awareness, interest, and community activity in the problems of an aging population; to provide a medium for the exchange of knowledge and information pertaining to gerontology; and to give advisory and consultant services to interested organizations and agencies."

Membership in the society is open to any person interested in the aims of the organization.

Governor Lodge had encouraged the organization of this group when he stated he felt a firm conviction that much interest and planning for the older age group had been indicated for some time.

At the first meeting Professor Walter McKain of the Department of Sociology, University of Connecticut, outlined some of the studies done on older people by that department during the last three years. He emphasized the emotional difficulties in the process of aging and adjustment to retirement, which, he pointed out, should be a challenge to both the medical profession and workers in other scientific disciplines to find an adequate answer.

Miss Harriett Wilcoxson, public health nursing consultant, State Department of Health, presented a summary of medical diagnoses and handicaps being serviced by representative visiting nurse associations as disclosed by a survey conducted during the summer and early fall of 1953. The major conditions were found to be diseases of the heart and blood vessels, cancer, arthritis, mental deterioration and anemia (which might be symptomatic of other underlying disease).

Both speakers stressed that women constitute the bulk of the older population. Slightly more than 80 per cent of the people with a medical diagnosis require assistance from another person in activities of daily living, according to Miss Wilcoxson, while Professor McKain stated that only 8 per cent of the older people lived alone.

## THE PRESIDENT'S PAGE

### SPECIALIZATION AND THE GENERAL PRACTITIONER

**I**N a field as vast as medicine specialization is essential, inevitable, and will never be displaced. One wonders, however, if we are not becoming top heavy with specialists and if the process of board certification has not gone too far. Surgery is broken up into multiple specialties, each treating separate portions of the body, such as gynecology, orthopedics, urology, proctology, plastic surgery, thoracic surgery, neurosurgery, and recently cancer surgery. Medicine is divided into dermatology, allergy, cardiology, gastroenterology, neurology, as well as further subdivided by the arthritic, the diabetic, and the kidney specialist. Specialization tends to fragment medicine and a specialist is likely to see only the conditions related to his particular field of interest, rather than evaluate the patient as a whole.

The general practitioner who is in charge of the patient can best determine when special care is needed. It is his responsibility in guarding his patient's interests at all times to obtain consultation and specialty service when indicated. The well trained, educated, and experienced general practitioner of today is capable of diagnosing and treating 85 per cent of all illnesses. He should know his limitations and should seek counsel about the other 15 per cent.

The public has strayed away from reliance on the family doctor, owing largely to overemphasis of specialization. However, there seems lately to be a trend back to him with a beginning awareness of the proper relation between the general physician and the specialist. Nothing should succeed in replacing the family physician as the most important cog in the whole system.

To quote from Dr. Fred W. Rankin's recent Fellowship Address as the incoming president of the American College of Surgeons, "The old-time general practitioner has in large measure passed with the changing times. Perhaps that was inevitable, but it is still to be deplored. The cornerstone of medical practice should still be this type of physician, who represented, at his best, integrity, moral character, selflessness, willingness to serve with or without remuneration, and without consideration of his own time and comfort, because he was dedicated to the service of his fellowmen."

It is not my intention to belittle the well trained specialist who is essential and needed in our pattern of medical practice. This is a plea for a proper balance in our medical setup with a suggestion that we must go further in our medical schools and hospitals in encouraging and training qualified general practitioners.

George H. Gildersleeve, M.D.



## THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH  
*Director of Public Relations*

JOSEPHINE P. LINDQUIST  
*Administrative Assistant*

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

### COUNCIL MEETING

Thursday, January 14, 1954 — 3:00 P. M.

160 St. Ronan Street, New Haven, Connecticut

The January meeting of the Council was held at the offices of the Society in New Haven on January 14, 1954. The meeting was called to order by the Chairman at 3:00 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Gildersleeve, Marvin, Couch, Barker, Weld, Whalen, Fincke, Gallivan, Ursone alternate for Walker, Tracy, Gettings, Labensky, Gilman alternate for Ottenheimer. Alternate Councilors Drs. Ogden, Buckley, Otis. Speaker of the House Dr. Gibson, Vice-Speaker Dr. Feeney, Absent: Drs. Murdock, Walker, Flaherty and Ottenheimer. Alternate Councilors Drs. Gen and Archambault.

#### CONNECTICUT CHAMBER OF COMMERCE

An invitation that the Society become a member of the Connecticut Chamber of Commerce was considered. It was finally agreed that the Society not become a member of the Chamber.

#### MEMBER OF COMMITTEE ON PUBLIC HEALTH

The resignation of William J. Morse, New London, as a member of the Committee on Public Health was presented and Frederick W. Goodrich, New London, was appointed to succeed him.

#### COMMITTEE ON NATIONAL LEGISLATION

Dr. Thomas M. Feeney, Hartford, was named an additional member of the Committee on National Legislation from Hartford County and Dr. Joseph Fiorito, New Haven, was named an additional member of the Committee on National Legislation from New Haven County (3rd Congressional District).

#### DIRECTORS OF CONNECTICUT HOSPITAL SERVICE

The three present directors of Connecticut Hospital Service from this Society, Drs. Edward H. Kirschbaum, Albert W. Snoke and Edward J. Whalen, were renominated to be directors for the coming year. The chairman of the Council explained that it was rumored that the By-Laws of Connecticut Hospital Service were to be amended so that this Society and the Connecticut Hospital Asso-

ciation would no longer be given the privilege of nominating members of the Board of Directors of Connecticut Hospital Service. But, since no official information had been received to this effect from Connecticut Hospital Service, it was believed that the Council should proceed with nominating three directors as usual and so inform Connecticut Hospital Service.

#### DIRECTORS OF CONNECTICUT MEDICAL SERVICE

The present incumbents, Drs. Henry A. Archambault, Creighton Barker, Thomas J. Danaher, Louis F. Middlebrook, Thomas P. Murdock, Walter I. Russell, were renominated as directors of Connecticut Medical Service.

#### PROFESSIONAL POLICY COMMITTEE OF CONNECTICUT MEDICAL SERVICE

Drs. Orpheus J. Bizzozero, William H. Curley, Jr., Thomas M. Feeney, Robert G. Reynolds, Edward J. Whalen were named as members of the Professional Policy Committee of Connecticut Medical Service. Dr. Robert G. Reynolds replaces Dr. Denis S. O'Connor who did not wish to continue as a member of the Committee.

#### COUNTY ASSOCIATION OFFICERS CONFERENCE

The results of the questionnaire that had been sent to officers of the county medical associations asking

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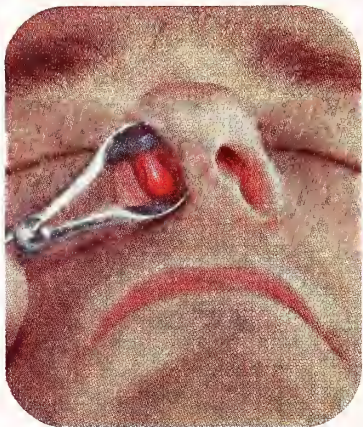
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them to express their opinion concerning holding the Annual Conference of County Officers was presented. (See Auxiliary Minute Book 1-14-54-"B"). After discussion it was concluded that there was not much enthusiasm in favor of holding the Conference in 1954 and it was suggested that the Program Committee for the 1954 Annual Meeting be asked to consider holding the County Officers Conference in conjunction with the Annual Meeting of the Society to be held in Hartford, April 27, 28 and 29.

#### AMA HOUSE OF DELEGATES RESOLUTION NO. 16

The secretary presented communications from George Lull, general manager of the American Medical Association, calling the Society's attention to the requirement included in Resolution No. 16, passed by the AMA House of Delegates at St. Louis, December 1953, in regard to cooperating with the Commission on Intergovernmental Relations (see Auxiliary Minute Book 1-14-54-"C"). The secretary was directed to inform Dr. Lull that this Society and its committees were ready to cooperate with the Commission on Intergovernmental Relations in any helpful manner as requested by the Commission.

#### COLLECTION OF FEES FOR SERVICES RENDERED BY RESIDENT HOUSE STAFF

The supplementary report of the Committee on Third Party Payments which had been presented for consideration at the meeting of the Council on November 19, 1953, was considered (see Auxiliary Minute Book 1-14-54-"D"). There was lengthy discussion of this matter and many objections to the recommendations in the report were voiced. It was finally voted:

(a) That the secretary thank the Committee on Third Party Payments for its efforts in connection with this subject and ask it to suspend further consideration of it for the present, and

(b) The Chairman of the Council endeavor to find out if the Connecticut Medical Service claim blank can be amended to permit a physician or surgeon to file a claim blank stating that he was responsible for the care of an insured patient although the services were actually rendered by a member of a resident house staff.

#### MANAGEMENT OF AMEF CAMPAIGN

Dr. William G. H. Dobbs, chairman of the Committee on Public Relations, joined the meeting at

this time. A resolution passed by the Committee on Public Relations at a meeting on November 19, 1953 was presented as follows:

"Resolved: That AMEF fund-raising activities be transferred to another committee and that the Society's Council consider employment of a fund-raising organization to accomplish the purposes of the campaign."

Dr. Dobbs explained the operations of the AMEF Campaign at interesting length (see Auxiliary Minute Book 1-14-54-"H"). He stated that in his opinion the objection on the part of the members of the Public Relations Committee to continue to operate the Campaign was because of the large amount of time and work involved in organizing teams to make personal solicitations. He also stated that the 1953 results in the campaign using personal solicitations were not as good as in 1952 campaign when postal solicitations were relied upon. He thought probably that the Committee on Public Relations would be willing to continue to supervise and make policy concerning the AMEF Campaign if it did not entail personal solicitation and that he was willing to continue as chairman of the committee. It was voted that Dr. Dobbs ask the Committee on Public Relations at its meeting to be held next week if it would be willing to continue to supervise and direct AMEF Campaign with the understanding that only postal solicitation would be utilized. It was also agreed that the employment of a fund raising organization as suggested by the Committee on Public Relations was not practical.

#### A BOOKLET ON PREVENTION OF MALPRACTICE SUITS

A resolution from the Committee on Public Relations passed at its meeting on November 19 was presented as follows:

"Resolved: That this committee recommend to the Society's Council publication of a booklet on prevention of malpractice suits for distribution to physicians in Connecticut."

Copies of a booklet on this subject prepared by and for members of the Texas State Medical Society were distributed by the secretary. The secretary noted that there had been informal consideration of obtaining this booklet from Texas for members of the Connecticut State Medical Society, but there were details in the booklet that were applicable only to Texas and considerable revision would be required



to make it useful in this State. The detail and expense of preparing, editing and publishing a booklet of this kind were discussed at length. The secretary then called attention to the fact that the Council on Medical Service of the AMA is now engaged in a study of professional liability insurance and malpractice actions in the United States and it is possible that the Council on Medical Service may contemplate the preparation of a booklet on the presentation of such cases to supplement the exhibit material which the Council makes available on this subject.

It was agreed that the Society should not proceed with the preparation of its own booklet at this time and that the secretary should communicate with the Council on Medical Service to see if such a booklet is being planned by the Council and if not, to suggest that it be done.

A motion passed by the House of Delegates at the Semi-Annual Meeting on December 10, 1953 that "proposals made by Connecticut Medical Service be referred to the physicians of Connecticut with an opportunity for them to be discussed at the county level" was recalled to the Council (see Auxiliary Minute Book 1-14-54-"E"). The secretary presented a letter which he had written to Dr. Samuel Spinner, the maker of the motion, asking Dr. Spinner his intent in reference to that part of the motion which says that the proposals . . . "be referred to the physicians of Connecticut."

The secretary asked the Council to determine if the publication in the CONNECTICUT STATE MEDICAL JOURNAL of the CMS proposals, on page 47 of the January issue of the JOURNAL, was sufficient to carry out the provisions of the Spinner motion that the CMS proposals "be referred to the physicians of Connecticut."

It was voted that the publication in the JOURNAL was sufficient for the purpose noted.

#### CONNECTICUT NUTRITION COUNCIL

Continuation of the Society's membership in the Connecticut Nutrition Council was discussed and it was voted that the Society continue its membership for 1954 and Dr. Stewart P. Seigle, Hartford, be named as a delegate from the Society to the Council to serve with Dr. Max Caplan, Meriden.

#### A RESOLUTION CONCERNING THE CMS CONTRACT

A resolution from a group of physicians of New Britain concerning the revision of the subscribers'

contract of Connecticut Medical Service was presented (see Auxiliary Minute Book 1-14-54-"F"). The proposed revision would make substantial changes in the provisions for payment for services of physicians for nonsurgical services.

Dr. Danaher reported that he had received a copy of this resolution as chairman of the Committee on Professional Policy of Connecticut Medical Service and that it had also been sent to the county medical associations. He stated that it was his intent to meet with this group of physicians in New Britain this evening following adjournment of the Council meeting. The matter was generally discussed, and it was finally concluded that it belonged in the Committee on Professional Policy of CMS rather than before this Council. It was then voted that the subject be referred to the Professional Policy Committee of CMS and to the Hartford County Medical Association.

#### COMMITTEES DISCONTINUED

It was voted that the Medical Advisory Committee to the Veterans Placement Board and the Advisory Committee to the State Health Department on Psychiatric Clinics be discontinued.

#### STUDENT MEMBERS ELECTED

Allan G. Bennett, Thompson  
Western Reserve—Class of 1957  
Pre-Med: Oberlin College  
Parent: Alva H. Bennett

Seymour Byer, New Britain  
George Washington University—Class of 1957  
Pre-Med: George Washington University  
Parent: Louis Byer (deceased)

Anthony J. Giorgio, Hartford  
Boston University—Class of 1957  
Pre-Med: Boston University  
Parent: Nicholas A. Giorgio, M.D.

Bernard L. Kaye, New Haven  
Harvard Medical School—Class of 1955  
Pre-Med: Yale  
Parent: Reubin Kuklinsky

Richard P. Lena, New London  
Tufts Medical School—Class of 1957  
Pre-Med: Dartmouth College  
Parent: Hugh F. Lena, M.D. (deceased)

Salvatore M. Santella, East Norwalk  
Creighton Medical—Class of 1957  
Pre-Med: Fairfield University  
Parent: Nicholas Santella

Richard A. Smith, Norwalk  
Howard University—Class of 1957  
Pre-Med: Howard University  
Parent: Julius R. Smith (deceased)

The meeting adourned at 6:15 P. M.

#### NOTE

A new method of filing records of the Council is to be instituted commencing with this meeting. In the future, all supplementary data and exhibits will be filed in a separate volume, the Auxiliary Minute Book (AMB). The symbols in the minutes, AMB 1-14-54, a, b, c, etc., refer to file numbers of those documents in the Auxiliary Minute Book.

## THE COUNCIL WILL MEET AT THE OFFICES OF THE SOCIETY ON FEBRUARY 11.

### Meetings Held During January

- January 6—Woman's Auxiliary  
Connecticut Medical Examining Board
- January 7—Nominating Committee  
Conference Committee with State Bar Association
- January 12—Connecticut Health League
- January 13—Committee on Maternal Mortality and Morbidity
- January 14—Council Meeting
- January 18—Conference Committee with American Legion
- January 19—Program Committee—Annual Meeting
- January 20—Committee to Study Neonatal Mortality  
Committe on Industrial Health  
Advisory Committee to Welfare Department
- January 21—Committe on Public Relations  
Committee on School Health

## Hartford Hospital Advances Research

For the past few years there has been a growing interest on the part of the Board of Directors and the Medical and Surgical Staff of the Hartford Hospital in the development of a definite program of research. Mr. William H. Putnam, chairman of the Board, has been instrumental in securing financial aid from individuals and corporations in the Hartford section. Already \$65,000 is on hand, the gift of Aetna Life, Connecticut General, Connecticut Mutual, Phoenix Mutual and Travelers Insurance Companies. Ralph M. Tovell is chairman of the research committee and has announced that priority will be given cardiac and respiratory diseases in the program. A fulltime research director has been recommended by the staff as soon as funds become available.

Of interest to all is the new giant radioactive cobalt therapy unit which the Hartford Hospital has ordered for super voltage radiation therapy of cancer. This unit is called the "theratron," will deliver the equivalent radiation of a 2 million super voltage x-ray unit, weighs 16,000 pounds, and will cost close to \$90 thousand. The purchase of this unit has been made possible by a gift of \$100 thousand from the United Aircraft Corporation. The cost of installation of this unit will be an additional expense. So far as is known there is but one other unit of this kind in operation in this country.

Other improvements in the radiological and physical medicine departments have been made possible by the gift of \$26,750 from the Hartford Foundation for Public Giving. These include the installation of a combined fluoroscopic and radiographic unit for use in the diagnostic clinic, and moist air equipment for the physical medicine department.

## Connecticut Health League Elects

Physicians figured prominently in the recent elections of the Connecticut Health League. Charles C. Wilson, professor of health and education in the Department of Public Health at Yale, was re-elected president; Luther K. Musselman of New Haven, delegate from the State Medical Society, was re-elected vice-president; and Stanley H. Osborn, State health commissioner, and R. C. Edson, superintendent and medical director of Cedarcrest Sanatorium, were elected to the board of directors.



## THE HISTORIAN'S NOTE BOOK

### THE HARTFORD HOSPITAL, 1854-1954

LYDIA B. HEWES, *Hartford*

IN 1854 Hartford has a handsome city hall of Bulfinch design, several fine churches, paintings are on exhibit in the Wadsworth Atheneum. There are eight public grammar schools, an orphan school, a Catholic School and an African School. The new Hartford Public School High that cost \$15,000 stands at the corner of Asylum and Ann Streets. There is a private Academy, the first Deaf and Dumb Asylum in the U. S. A., and on the hill, where the State Capitol will rise in the future, stands Trinity College. The Governor of Connecticut in 1854 is Thomas H. Seymour with a salary of \$1,100. William J. Hamersley is the Mayor of Hartford. The residential district near the river front and at the south end boasts substantial houses. Carriages are in demand at the livery stable on Broad Street. There are horse-drawn omnibuses that leave from Asylum and Main three times a day for West Hartford. Busy traffic in boats plies the river, which is crossed by a wooden covered bridge.

The City Hotel takes care of travelers at this mid-century period. People come and go by stage coach or arrive from New York by railroad. Horses clip clop along the streets drawing the carts and wagons of trade. One day a balloon makes a first ascension over Hartford, remaining in the air two hours to the astonishment of the populace. By 1854 several insurance companies have been founded, and the way is paved for the town's future title as "The Insurance City." Horse shoeing is a prosperous activity, carriage makers are busy, as well as harness, saddle, bridle and whip makers. Carpet bags, valises, feather beds and looking glasses are among the articles manufactured locally.

The news of the world is supplied by *The Hartford Courant* in the morning and *The Hartford Times* in the evening. During 1854 people read about the Crimean War in Europe, about the bravery of

Florence Nightingale nursing the wounded on the battlefields, of Japan being opened to commerce with the Western world. Livingstone is exploring in Africa, the United States is in the throes of arguments over slavery, the Kansas-Nebraska Act is passed, giving the states the right to decide whether to be slave or free, and "Uncle Tom's Cabin" by Harriet Beecher Stowe has added fuel to the emotional fire.

There is news in the papers of a yellow fever outbreak in the south, of a cholera epidemic in Niagara Falls. Some people are apprehensive because there is no public hospital in Hartford, the majority are complacent. Why borrow trouble? The city has a pest house and an Alms House, a Retreat for the Insane. There is a "Home for the Sick" at the south end, founded by a Committee of Christ Church in 1852, that cares for a small number of invalids. There are also about 25 physicians and surgeons covering the area by horse and buggy, as well as four homeopaths, four Thompsonian botanic physicians, one "natural physician" who claims miraculous cures for consumption, asthma and other ills, a psychomagnetic physician who can diagnose by clairvoyance. The drug stores are stocked with drugs, medicines and chemicals plus a good supply of German and Swedish leeches. There are women in town who are handy at caring for the sick.

There is no great demand for a hospital until March 2, 1854 when there is a terrible explosion. A boiler blows up at the Grove railroad car works, operated by the Fales and Gray Co. Nineteen people are killed and twenty-three injured. There is no place to take care of the victims. The city is shocked! There is a demand for action!

Hartford Hospital is founded in 1854 as a direct result of this accident!





### Dr. Bartlett Honored

On Friday December 18, 1953, Dr. Charles J. Bartlett was honored at a special meeting of the General Staff of the Grace-New Haven Community Hospital held in the memorial Unit. Many of Dr. Bartlett's old friends, and indeed many of his former pupils, were present to assist in honoring him. Dr. Charles Foote, who has passed his 92nd birthday, was also present. (Both Drs. Bartlett and Foote seemed to be very hale and hearty and in the best of spirits.) A number of communications were read from those who could not attend due to unfortunate other commitments.

The president of the staff, Dr. Daniel F. Levy, then read the following to Dr. Bartlett and the staff:

"When I was a student of medicine, my teacher of pathology was my good friend, Dr. Charles J. Bartlett. He not only taught pathology, but he also taught other subjects. Some of the students studied bacteriology under him and I am told that in the older days he also taught histology. I have known Dr. Bartlett chiefly as a pathologist and a clinician. He used to make rounds on the old alternating service at the New Haven Hospital and we certainly learned a great deal from him. During the many

years that I served as chairman of the Clinical Pathological Conference at the Grace Unit and at the Grace Hospital, Dr. Bartlett was most kind to me. He permitted me to scrutinize all of his autopsies and went over the pathological sections with me, if necessary. I then was able to correlate this material with the clinical findings and choose a case. The next step was to write a protocol. This protocol was read when I presided at the weekly Clinical Pathological Conference on Friday afternoons. Dr. Bartlett rarely missed a meeting. To him I owe more than I can ever express.

"On three previous occasions I have had the honor of telling my colleagues about Dr. Bartlett. I wrote a brief biological sketch of him which was first printed in the *Grace Hospital News* and later reprinted in the *CONNECTICUT STATE MEDICAL JOURNAL* in March 1943 under the title of 'Tribute to an Elder Statesman.' The second time that I was permitted to help honor Dr. Bartlett, in the presence of his colleagues and my colleagues, was when we handed him a bound volume, a *Festschrift*, containing articles written by many of us. This was on the occasion of his 80th birthday. The proceedings of that meeting were also reported in the *CONNECTICUT STATE MEDICAL JOURNAL*, but I have no reprints of them. Finally, when Dr. Bartlett retired, we had a dinner at the New Haven Medical Association building and I also was able to tell my friends and his what we all think of him.

"Today Dr. Bartlett is 89 years old. He has given up his active work, but I can assure you that he led a very active life indeed. Not only was he pathologist, attending physician, and head of the laboratories at the old Grace Hospital, but at the same time he was pathologist at the Charlotte Hungerford Hospital in Torrington, the Griffin Hospital in Derby, and at one time pathologist at the Meriden Hospital. He served on the Board of Health for many years and was director of laboratories in the State Department of Health. He was formerly president of the Connecticut Medical Examining Board. In my judgment and in the judgment of all of my colleagues, Dr. Bartlett has been and is a great and good man, and I believe that he is the most honest man in medicine whom I have ever met.

"It is, therefore, a great pleasure and a great privilege to speak to Dr. Bartlett on this occasion and to inform him that in his honor, in the pathological department of the Memorial Unit of the Grace-



New Haven Community Hospital, this bronze plaque will be placed. It reads:

CHARLES JOSEPH BARTLETT

PROFESSOR OF PATHOLOGY YALE UNIVERSITY  
SCHOOL OF MEDICINE

1900 - 1917

CHIEF OF LABORATORIES:—GRACE HOSPITAL AND  
GRACE UNIT OF GRACE-NEW HAVEN COMMUNITY  
HOSPITAL

1917 - 1948

"And now Dr. Bartlett, may I say extemporaneously something which I said to you on your 80th birthday. It is just a few lines from Stevenson's Underwoods.

"Contend, my soul, for moments and for hours;  
Each is with service pregnant; each reclaimed  
Is as a Kingdom conquered, where to reign."

Following the meeting refreshments were served and all of the assembled guests and members of the staff congratulated Dr. Bartlett. A picture of him smoking his pipe, one of his favorite poses, was exhibited framed. It is to be hung above the plaque.

### TB - Alcohol Lectures

Not infrequently one finds in tuberculosis sanatoria patients who, in addition to having tuberculosis, use alcohol excessively and in many cases addictively. This use of alcohol makes some of these patients difficult behavior problems while they are confined in a sanatorium for the treatment of tuberculosis. More importantly, the excessive and addictive use of alcohol by these patients often seriously lessens their chances for an effective response to the sanatorium's therapeutic regime directed at the treatment of their tuberculosis.

As might be expected from the nature of his drinking problem, the tuberculous alcoholic confined to a sanatorium frequently feels his first need to be alcohol and he will often go to extreme lengths to secure it. He will sometimes arrange to have friends bring it to him at the sanatorium or he will leave the institution without permission to secure it from the nearest source of supply. Whatever his method, his overindulgence presents serious administrative and treatment problems to the sanatorium and its staff. As is well known the ingestion of alcohol in large amounts can, for a time, fulfill the body's requirements for heat calories which are normally

derived from an adequate and balanced diet. The tuberculous patient who uses alcohol excessively consequently fails to receive the essential components of a normal, balanced and abundant diet which is so necessary to the treatment of tuberculosis. Rest, another very important element in the treatment of tuberculosis, is frequently neglected by the alcoholic or is taken spasmodically as physical exhaustion or the stuporous effects of excessive amounts of alcohol overcome him.

Perhaps in some cases the tuberculosis patient who drinks excessively does so because, knowing that he has tuberculosis, he feels that the situation for him is hopeless and therefore drinks to escape from his feelings of hopelessness and depression. In other instances the reverse might be true—the patient was an alcoholic before tuberculosis developed and its development followed more readily as the result of his improper diet, his inadequate rest, and his run-down physical condition.

The tuberculous patient with a drinking problem often presents an enigma to physicians and nurses who are dedicated to the treatment of tuberculosis. "What can we do," they ask, "to help an alcoholic patient with tuberculosis? What can we do in each instance to help him cooperate with us?"

In a staff of specialists charged with the care of the tuberculous and the treatment of tuberculosis, it is not difficult to understand how feelings of frustration and discouragement develop toward the tuberculous alcoholic patient. In spite of the most modern and thoughtful efforts directed at his recovery from tuberculosis, the tuberculous alcoholic often appears to willfully squander those efforts and his chances for recovery through his excessive indulgence in alcohol and in behaviors associated with that indulgence. Patients in this category will frequently leave the sanatorium against medical advice and return to an environment and to a way of life which are incompatible with the treatment of tuberculosis. If they remain at the sanatorium some of them will prove uncooperative and unresponsive to procedures directed at their recovery from tuberculosis, all the while taking every opportunity to secure and use alcohol—the advice and rules of the institution notwithstanding.

To take punishing measures against these patients by denying them certain privileges at the sanatorium or by discharging them from it will have little or no effect on their drinking behavior. In fact the

latter procedure probably often plays directly into the hands of the alcoholic who would rather be out of the sanatorium and where he can indulge in his drinking with less interference. This latter procedure, too, presents to the patient's family and to the public the serious health hazard of an active case of tuberculosis in an alcoholic who, if he follows the usual pattern, is notorious for his lack of concern for the health and welfare of others or for himself during the acute phase of his alcoholic excesses.

It is their concern with problems such as those alluded to above which led the Connecticut Tuberculosis Commission to seek the assistance of the Commission on Alcoholism in efforts directed at developing among the personnel at the sanatoria in the State a better understanding of the dynamics of alcoholism and of the techniques which have been found effective in its treatment. With the achievement of these goals among the key physicians, nurses and social workers at the sanatoria it is anticipated that the tuberculous alcoholic patients confined in those institutions can be more efficiently managed and more effectively guided toward physical and emotional rehabilitation.

As a result of discussion between representatives of the two Commissions it was decided that on a beginning and experimental basis the Commission on Alcoholism would present a series of nine lectures on the various aspects of alcoholism problems and their treatment at one of the State's four adult tuberculosis sanatoria. The sanatorium chosen for this pilot undertaking is Cedarcrest at Newington. The lectures, which will be given on the first Wednesday of each month from 10:00 to 11:00 A. M. in the auditorium, will be followed by a discussion period. The Tuberculosis Commission will invite Cedarcrest's staff of physicians, nurses, social workers and other key personnel as well as certain members of the staffs of the other outlying sanatoria and of local public and private social and welfare agencies. Lecturers will be drawn from among the staff of the Connecticut Commission on Alcoholism and from the Yale Center of Alcohol Studies. At the close of each lecture selected literature on the particular alcoholism problem area presented will be made available to those desiring it for further reading.

The titles of the remaining lectures and the names of the lecturers follow:

Four lectures have already been given in October-January, inclusive.

February—The Role of the Nurse in the Treatment of Alcoholics. Miss Mary Toner, R.N., M.A., nurse supervisor, Blue Hill Hospital.

March—Using Community Resources in a Rehabilitation Program. Mrs. Jean V. Sapir, M.A., M.S.S., supervisor of Psychiatric Social Service, Commission on Alcoholism.

April—The Program of Alcoholics Anonymous. Mr. R. M. H.

May—Community Attitudes Toward Alcoholism and the Alcoholic. Raymond G. McCarthy, M.Ed., director of Alcoholism Research, New York State Mental Health Commission.

June—The Development of State Supported Programs for the Rehabilitation of Alcoholics. Dudley Porter Miller, Ph.D., executive director, Connecticut Commission on Alcoholism.

The Commission on Alcoholism looks forward to its opportunity to cooperate with and be of assistance to the Tuberculosis Commission. Both of these agencies anticipate the possibility that the lecture series currently being undertaken at Cedarcrest can, if it proves effective, be presented at each of the other sanatoria during subsequent years and that out of these efforts will gradually grow a mutually planned and cooperative program directed at the rehabilitation of the tuberculous alcoholic in Connecticut.

In order to more closely approach the complex problems of the alcoholic with tuberculosis, the Tuberculosis Commission has invited representative workers from the Commission on Alcoholism to be present at routine staff conferences and at rehabilitation team conferences. This arrangement permits active participation and coordination of effort at the same time that it fosters a more thorough understanding of the dual problems of the representatives of each Commission. It is hoped and expected that this cooperative program will result in direct benefit to the patient.



## Residence Hall for Medical Students at Yale



General plans for the construction of the new Edward S. Harkness Memorial Residence Hall, generous gift of the Commonwealth Fund, have been completed as the result of several meetings of the Building Committee with the architects, Douglas Orr of New Haven and Gugler, Kimball & Husted of New York. Many details remain to be settled, but it is hoped that ground can be broken early in 1954 and that the new quarters for Yale medical students can be finished and equipped for occupancy in September 1955.

Plans have been made for an L-shaped red brick structure on the triangular lot, adjacent to the School of Medicine, bounded by Davenport, York, and Oak Streets. One wing, of eleven stories and ground floor, will provide 219 single rooms for male students, as well as ten suites for students or graduate advisors. The other wing, four stories high, will contain thirty-five small apartments. The latter will be occupied by pairs of single women students and by a few married medical students and their wives. The single rooms will include lavatories and built-in closets. Shower rooms will be provided on each floor. The apartments will consist of a living room, bedroom, bath, and kitchenette unit. The apartment wing will have its own entrance and will also communicate with the main lounge. Each wing will have its own automatic elevators. Other living quarters will include a large apartment for a resident manager and his family and a living room-bedroom-bath combination for the accommodation of visiting lecturers and other guests of the school.

The building will be approached over a lawn

and large terrace. Adjacent to one part of the lobby will be a control desk and switchboard, mail boxes, the entrance to the cafeteria, elevators to the men's wing, and a coat room and lavatory. A large section of the lobby will lie between the cafeteria and lounge. It will be possible to use all three areas for parties, and for such occasions a special entrance leading directly from York Street will be opened. Nearby, on the second floor, will be a small library. Lounge, cafeteria and lobby, all large rooms, will be located at the angle of the L formed by the two residence wings.

There will be ample provision for feeding students. Adjacent to the spacious cafeteria which, like the lounge, will be two stories high, a kitchen, food storage rooms, locker rooms for dining room employees, a dietitian's office, etc., will be established on the main floor and on the ground floor below. Private dining rooms will be available for luncheon meetings of committees and conference groups. A separate snack bar, also on the ground floor, will be open for the refreshment and relaxation of students returning from long evenings in the library or wards. The ground floor will include, in addition to the grill, quarters for a variety of uses, among them a music room, a photographic dark room, a carpentry and hobby shop, rooms available for offices for fraternities and the Student Council, an exercise room, storage and utility rooms, receiving platforms, and a laundry where, according to plan, coin operated washing machines and driers will be installed. Space will be available on the roof for sun decks and paddle tennis.

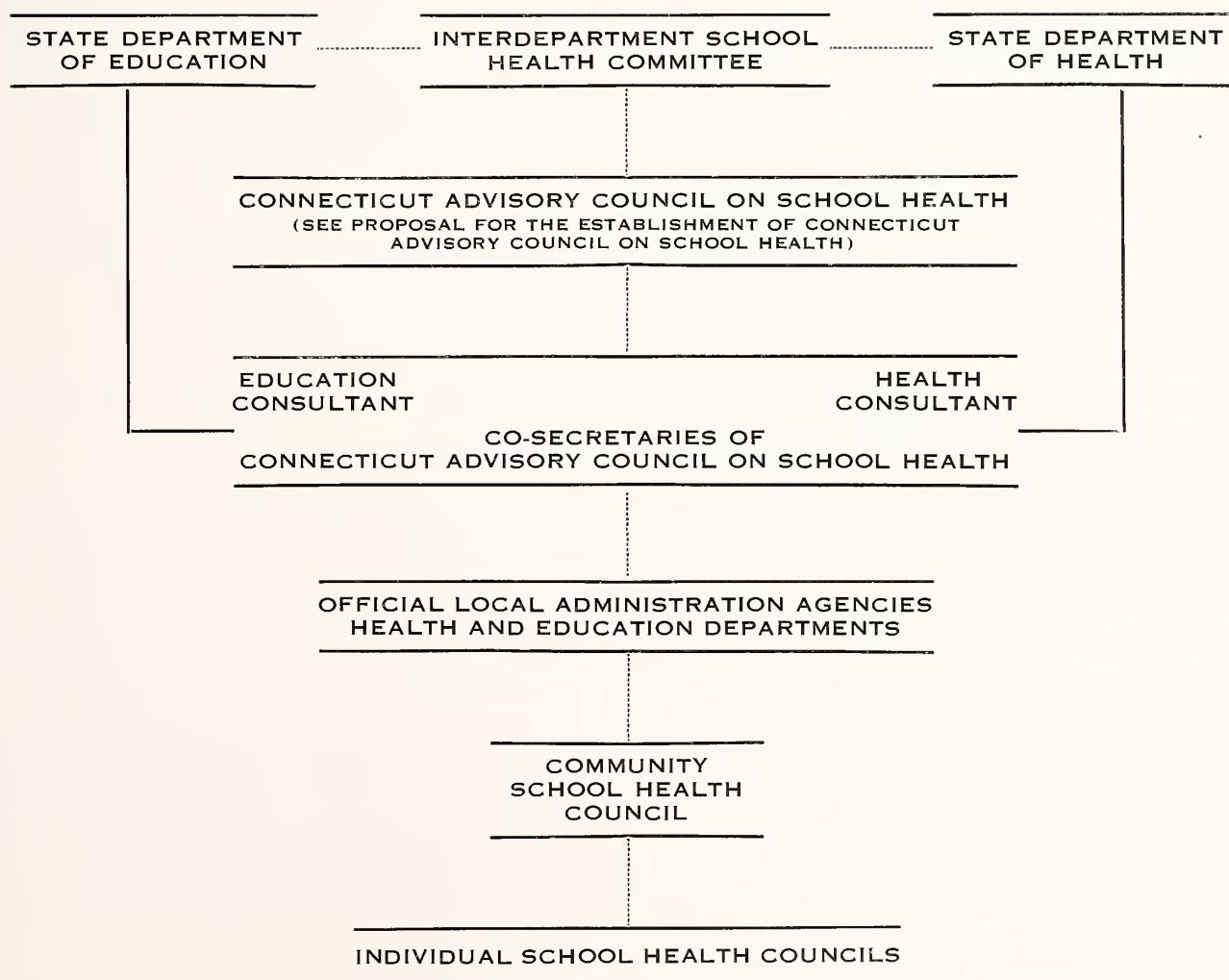
## New State Advisory Council on School Health

The Subcommittee on School Health of the Connecticut State Medical Society, after extensive study, has recommended that a Connecticut Advisory Council on School Health be appointed jointly by the State commissioners of education and health. This recommendation has been approved by the Committee on Public Health and by the Council of the Connecticut State Medical Society. The two commissioners, in approving this proposal, have each agreed to make personnel available from their staff to serve as cosecretaries of the proposed Connecticut Advisory Council on School Health.

The members of the Subcommittee on School Health include five members of the State Society, the State Commissioner of Education, the State Commissioner of Health, a representative of the Connecticut State Dental Association, and a representative of the Yale University School of Medicine, Department of Public Health. Charles A. Murphy, M.D., of Stamford, was appointed chairman.

This subcommittee was appointed as a result of an action taken by the Committee on Public Health at its meeting on June 12, 1952 following a discussion of problems and needs centering around school health services. The chairman of the public health committee was empowered to appoint this Subcom-

CHART SHOWING PROPOSED COOPERATIVE RELATIONSHIP OF  
CONNECTICUT ADVISORY COUNCIL ON SCHOOL HEALTH\*



\*As suggested by Subcommittee on School Health of the Committee on Public Health of the Connecticut State Medical Society



nittee on School Health to study some sixteen related problems.

In addition to cooperating with the Connecticut Advisory Council on School Health, the Subcommittee on School Health will continue its work on the original suggestions made by the Committee on Public Health and will study ways in which members of the medical profession can assist in local programs for improving the health of school children.

The following is a statement of the Proposal for the Establishment of Connecticut Advisory Council on School Health and a Chart showing Proposed Cooperative Relationship of Connecticut Advisory Council on School Health appears above.

#### PROPOSAL FOR THE ESTABLISHMENT OF CONNECTICUT ADVISORY COUNCIL ON SCHOOL HEALTH

The Subcommittee on School Health of the Committee on Public Health of the Connecticut State Medical Society has been studying the need for a state-wide advisory group to improve the total health program which includes health environment, health services, health instruction, physical education and safety in the schools of Connecticut. Growing out of their deliberations, a proposal for the establishment of a Connecticut Advisory Council on School Health is offered.

One of the major interests and objectives of the Subcommittee on School Health of the Connecticut State Medical Society is to encourage the development of local school health councils as a means of coordinating local interests toward improvement of the programs in the local schools. This objective would be a logical and fundamental goal of a state advisory council.

#### PURPOSE

The major purpose of the proposed Council is to bring together official representatives of the various agencies and groups (governmental and voluntary) which have a direct responsibility and interest in and who have a contribution to make to the development and improvement of the school health program, in order to stimulate interest and provide assistance to local programs and coordinate through local school health councils or committees various aspects of the program.

More specifically, such a Council will advise and work with official representatives of the Connecticut State Departments of Education and of Health, two

of whom will serve as coexecutive secretaries of the Advisory Council. The Council will provide channels for advice and assistance among lay groups, voluntary professional groups and the agencies legally responsible for the school health program.

#### DESCRIPTION

Official representatives from the following groups are suggested for membership in the proposed Council: Connecticut Association for Health, Physical Education and Recreation; Connecticut Boards of Education Association; Connecticut Chapter of American Academy of Pediatrics; Connecticut Education Association: Classroom Teachers Section; Connecticut Health League; Connecticut League for Nursing; Connecticut Public Health Association; Connecticut School Social Workers Association; Connecticut State Dental Association; Connecticut State Medical Society; Elementary School Principals Association; Local Directors of Public Health; Parent-Teacher Association of Connecticut, Inc.; School Nurses Association of Connecticut; School Superintendents Association; Secondary School Principals Association; Woman's Auxiliary of the Connecticut State Medical Society; Yale University School of Medicine, Department of Public Health.

Coexecutive secretaries are suggested, one each from: Connecticut State Department of Education; Connecticut State Department of Health.

#### ORGANIZATION AND FUNCTION\*

The attached chart serves to show in broad outline the suggested organizational pattern, channels and relationships.

It is clearly understood that the Council will serve only in an advisory capacity since the administrative responsibilities rest with the legally responsible State departments. The Council will function in an advisory role in studying and encouraging improvement of all aspects of the school health program.

Through the representatives on the Council and the official departments, many resource consultants can be made available to committees set up by the departments: for example, in medical, dental and nursing policies, school administration, mental health, curriculum construction, child growth and development, sanitation, preventable diseases, nutrition, and so on.

\*School Health Policies and other pertinent literature to be used as guides.

## CONCLUSION

It is the considered opinion of those concerned, who have definite responsibility to promote and improve the school health programs in Connecticut, that the formation of a state advisory council on school health will offer a much needed clearing house and advisory organization on the state level which can give vital aid to improving and strengthening the local school health programs for the benefit of the children of Connecticut.

### Accident Toll High Among the Aged

Accidents are a major threat to the life of the aged, outranking every other cause of death except the cardiovascular diseases and cancer, according to *Statistical Bulletin* of the Metropolitan Life Insurance Company. Of the 100,000 deaths from accidents in the United States annually, about 25,000 occur among people at ages 65 and over. These elders thus contribute one-fourth of all the victims of fatal accidental injury, although they comprise only 8 per cent of the total population. The death rate from accidents reaches its highest level at ages 65 and over, where it is three times the rate at ages 45-64 and seven times that at ages 1-14.

Physical weakness, impaired motor function, forgetfulness, poor vision, and other infirmities of later life make the aged particularly prone to mishaps. Moreover, when these people are involved in accidents, the results are likely to be serious. At the older ages bones break rather easily and do not join very readily; burns, cuts, and other types of injury do not heal rapidly. In addition, serious complications, such as pneumonia, may set in, while chronic disease—common among the aged—may have a fatal termination.

Recent data on the various types of fatal accidents among people at ages 65-74 are available from the experience among the Industrial policyholders of the Metropolitan Life Insurance Company, most of whom are urban residents.

Three-fourths of all the fatal accidents among these older policyholders were due to two types of mishaps—falls and motor vehicle injuries. Among men at ages 65-74 motor vehicle injuries were the

leading cause of accidental death, outranking by a small margin the toll exacted by falls. Among women at these ages, fatal falls were far ahead of every other type of accidental injury, accounting for well over half the total. Even though motor vehicle injuries ranked second, they were still responsible for nearly one-fourth of all the accidental deaths among these women.

In terms of actual death rates, the total accident mortality among males was not far from twice that for females. Moreover, the toll from motor vehicle accidents was virtually three times as great for men as for women at ages 65-74. The wide sex difference in the mortality from motor vehicle accidents reflects mainly the higher proportion of time spent by men on streets and highways. In each sex the majority of such fatalities were among pedestrians, indicating the difficulty that older people have in coping with modern traffic conditions. Yet a substantial proportion of the fatalities also occurred among drivers and passengers in motor vehicles.

Fatal falls likewise occurred under a variety of circumstances. In this insurance experience a considerable proportion were falls from one level to another. Stairs and steps accounted for the majority of such fatalities, with falls from windows, porches, and other high places also about the house. Illness or physical weakness played a major role in many of these cases.

Among the other types of accidents which caused death among the aged, burns and conflagrations were important items. Drowning, railway, machinery, and firearm accidents, while relatively infrequent as causes of death among the women, accounted for an appreciable death toll among the men.

Accidents are much more amenable to control than any of the other major causes of death among the aged. The record for the past two decades shows that the mortality from accidents at the later ages has declined more rapidly than that from disease. Further progress could be made if elders learned to adjust their habits in accordance with their changing physical condition and if their environment, particularly in the home, were made as free from hazard as possible.



## NEWS FROM WASHINGTON

PRESIDENT EISENHOWER IN HIS SPECIAL MESSAGE TO CONGRESS ASKED FOR \$25 MILLION TO INAUGURATE A SYSTEM OF GOVERNMENT REINSURANCE OF PRIVATE PLANS TO HELP TAKE CARE OF EXTRAORDINARY EXPENSES BEYOND THOSE NOW COVERED. IN ADDITION HE PROPOSED A FIVE YEAR PLAN FOR EXPANSION OF THE REHABILITATION PROGRAM FOR THE DISABLED; A CONTINUATION OF PRESENT PUBLIC HEALTH SERVICE PROGRAMS; A NEW, SIMPLIFIED FORMULA FOR GRANTS IN AID TO THE STATES FOR HEALTH PURPOSES; AND AN ACCELERATED PROGRAM OF CONSTRUCTION OF MEDICAL CARE FACILITIES. (See Page 165 for details.)

### Reed Indicates Physicians Will be Excluded From OASI Bill

Chairman Daniel A. Reed (R-N. Y.) of the House Ways and Means Committee has indicated that in his opinion Congress should not force mandatory social security coverage on physicians and others who don't want it. Mr. Reed's committee will hold public hearings after the first of the year on the administration's proposal to extend Old Age and Survivors Insurance to about 10,500,000 more persons. The administration bill, introduced last August, would mandatorily take in physicians, dentists, farmers and virtually all other groups of self employed.

In a statement outlining the committee's plans, however, Mr. Reed made clear that he is not in favor of compulsory coverage for groups that oppose coverage. He declared: "I believe that social security coverage should be extended to any group which desires it." At its meeting earlier this month in St. Louis, the AMA's House of Delegates reaffirmed that the country's physicians do not desire social security.

Other committee objectives, as stated by Mr. Reed: Liberalize the present \$75 per month limit on earnings of OASI recipients, raise the level of minimum benefits and allow the social security tax to go up one half per cent as scheduled on January

1. Mr. Reed said that in the hearings "every interested group will be given an opportunity to testify."

### Four Groups at Work Within Hoover Commission Medical Task Force

To facilitate the gathering of information from government agencies and other sources, the Hoover Commission Medical Task Force has separated itself into four divisions. The finding will be "considered fully by the whole Task Force," according to the commission, before any conclusions are reached or any recommendations made. The makeup of the four teams:

Medical Services of the Armed Forces—Drs. E. D. Churchill (chairman), Michael DeBakey (co-chairman), Walter Martin, president-elect of the AMA, and Dwight L. Wilbur. Medical Services of the Veterans Administration—Drs. Basil C. MacLean (chairman), Francis J. Braceland, Evarts A. Graham, and Otto W. Brandhorst. Medical Services of the U. S. Public Health Service and Other Federal Services—Drs. Theodore Klumpp (chairman), Hugh Leavell (vice-chairman), and Milton C. Winternitz. Overall Planning for Medical Services in Time of War—Drs. Paul Hawley (chairman), Alan Gregg (co-chairman) and James Roscoe Miller.

The commission also announced that Dr. James P. Dixon, formerly Philadelphia health officer and

formerly acting director of the Clinical Center at Bethesda, Maryland, will be secretary of the Task Force and an assistant to Dr. Edwin L. Crosby, the research director.

### **Tax Deferments for Annuities (HR10, HR11)**

Pending before the House Ways and Means Committee is legislation permitting the self employed, including physicians, to defer, until retirement, income tax payments on a limited portion of earnings paid into restricted annuity plans. The legislation, popularly known as Jenkins-Keogh for its two principal sponsors, was the subject of hearings last August, after Congress had adjourned. The proposal is certain to be reopened when the Ways and Means Committee takes up revisions of the income tax laws this season.

The Association strongly supports Jenkins-Keogh legislation and has urged its passage in lieu of extending social security coverage to physicians. AMA cites the fact that present law permits corporations to contribute to their employees' pension plans on a tax-free basis. The self employed, on the other hand, are denied a similar advantage.

### **Deductions for Medical Expenses (HR3911 and others)**

Nearly a score of bills before the House Ways and Means Committee propose to amend the income tax law to allow larger deductions for medical expenses. Present law permits deductions of expenses exceeding 5 per cent of taxable income, with a ceiling of \$1,250 for each taxpayer and equal amounts for dependents, the combined total not to exceed \$5,000. Some bills would remove the 5 per cent limitation entirely but retain the ceiling (HR3779 by Rep. Selden) while others would remove both ceiling and percentage limit (HR3911 by Rep. Oliver Bolton). Another (HR474 by Rep. Keating) provides for a graduated scale of medical cost deductions based on adjusted gross income; expenses would include amounts paid out for accident and health insurance. Chairman Reed has promised that consideration of tax law revisions will be the first order of business for the House committee in the new session.

The Association approves the legislation in principle and cites the fact it would afford individual

relief in cases of extremely high medical expenses and would also be an incentive for purchase of voluntary health insurance.

### **Waiver of OASI Premiums (HR9 and others)**

Pending before the House Ways and Means Committee are several bills that would permit totally and permanently disabled workers to receive full OASI benefits on reaching age 65, just as though they had worked during the disablement period. The bills would give the Secretary of Health, Education, and Welfare final authority on medical determinations.

The Association has actively opposed all measures so far presented on these two subjects, pointing out that they (1) place too much authority in the federal government, (2) provide for compulsion, (3) are considered a further interference in the practice of medicine, and (4) needlessly subject the examining physician to criticisms and pressures. In the case of waiver of premiums, the AMA recommends using the best 10 years of earnings to determine the retirement rate for all beneficiaries, thus obviating the need for medical examinations in almost all cases of disability.

### **A Health Insurance Bill to Provide Federal and State Grants**

A Health Insurance bill to provide federal and state grants to assist voluntary non profit prepayment health plans has been introduced in both houses by Senators Ives and Flanders and Representatives Javits, Hale and Scott. The plan provides that the premium for insurance be based on a percentage of the income of the insured with Federal and State grants-in-aid making up the difference between the standard premium and what the individual can afford to pay. The bill also places primary responsibility for the development of adequate health services with the states, local communities, non profit health plans and the medical profession. Mr. Javits supported his argument for the bill by stating that a survey made by the University of Michigan Survey Research Center for the Federal Reserve Board revealed that nearly one-third of the 15 million families in which the head is less than 45 years of age and where the children are under 18 owe medical bills. According to this source, of all the money spent privately for medical care in the U. S., about \$1 out of every \$9



remains as a debt to a doctor, hospital or pharmacist. This condition exists despite the fact that more than half of the nation's population has some sort of insurance coverage against sickness.

### Hospitalization of Aged (HR8 and others)

Dormant but not dead are several bills in the House Ways and Means Committee providing free hospitalization for persons over 65 who are OASI beneficiaries. The plan, first proposed by Oscar Ewing, affords up to 60 days of hospital care in any one year, the program to be financed from the OASI Trust Fund. The secretary of HEW would have the power to operate the program in any state that failed to cooperate. Attending physicians would certify need for hospitalization.

The Association is opposed; it takes the stand that the proposal is financially unsound and places too much authority in the hands of the secretary of HEW.

### PVP Gets Clean Bill as Blood Expander From NRC

Release into commercial channels of blood volume expander PVP (polyvinylpyrrolidone) is now up to Food and Drug Administration. Committee on medicine and surgery of National Research Council, climaxing a 3 year study, has approved PVP and informed FDA that all evidence indicates it may be administered safely provided dosage is limited to 1,000 cc. NRC long ago assented to stockpiling of PVP for civil defense and emergency use exclusively. Its latest action paves way for introduction into general utilization, contingent upon favorable action by FDA. Chief suppliers of PVP are Schenley, Abbott and General Aniline.

### Health Books and Foods Curbed by FTC Order

Federal Trade Commission has thrown the book at an Ohio firm engaged in sale of health books, devices, foods and drugs. An order issued by FTC against Natural Foods Institute of Olmsted Falls prohibits further advertising claims that: Cancer can be relieved or cured by treatment described in a book, "The Grape Cure;" Dr. Gaymount's Yogourt Culture is useful against ulcers; arthritics, diabetics and asthma sufferers will benefit by following recommendations presented in book called "Raw

Vegetable Juices;" use of a device known as "Vita-Mix" will improve eyesight or benefit teeth and another gadget ("Juicex") will assure health and vigor. FTC also ordered the company to drop "Institute" from its trade name.

### Rehabilitation Effort Places 61,308 in Jobs

Miss Mary E. Switzer, vocational rehabilitation director in Department of Health, Education and Welfare, reports that for third successive year the state-federal program which she supervises enabled more than 60,000 physically handicapped persons to become self supporting. Actual figure for fiscal year ended June 30, 1953 was 61,308, approximately one-fifth of whom had been on public relief rolls. It cost \$6.3 million to rehabilitate these indigent handicapped for employment, compared with \$8 million to maintain them on relief for one year.

Emphasizing that vocational rehabilitation is self liquidating, Miss Switzer estimated that the men and women returned to employment in 1952-53 will pay back Federal income taxes at an annual volume of approximately \$10 million. Thus in less than two and one half years they will restore the \$23 million that was invested by Treasury (states contributed \$11.6 million for the year).

### Home Town VA Care

For home town, fee-basis medical care, Budget Bureau has released \$2 million of the \$2,783,000 in Veterans Administration funds which it impounded last summer for economy purposes.

### \$6.42 Million Approved for 651 Research Grants

Surgeon General Leonard A. Scheele of U. S. Public Health Service has approved award of 651 medical research grants in aid which come to total of \$6,428,435. His action was taken on recommendations by advisory councils to National Institutes of Health at their November-December meetings. In February the councils meet again to allocate the small amount remaining from \$28,866,000 that was appropriated for research grants in 1953-54. At that time they will also start consideration of applications for fiscal year beginning next July 1, although sums to be available will still be uncertain. Here is rundown on new approvals:

Arthritis and metabolic diseases—67 projects, \$606,031; applications totaled \$1,003,116, for 98 projects.

Neurological diseases and blindness—49 projects, \$441,312; applications, \$1,838,071, for 97.

Cancer—215 projects, \$2,055,155; 253 applications for \$2,654,120.

Dental—5 projects, \$20,342; 11 applications for \$74,390.

Microbiology—64 projects, \$579,060; 100 bids for \$867,189.

Heart—93 projects, \$1,058, 636; 152 for \$1,878,298.

Mental health—67 projects, \$821,963; 123 for \$1,884,291.

General—91 projects, \$845,936; 137 applications for \$1,467,511.

National Institute of Arthritis and Metabolic Diseases is making available a limited supply of radioactive corticosterone (Compound B) to investigators without charge. Information is obtainable from Endocrinology Study Section, National Institutes of Health, Bethesda 14, Maryland.

## Eisenhower Administration's Medical and Health Program

1. A federal corporation to reinsure commercial and non profit health insurance plans.

2. Liberalization of income tax laws to allow more deduction for medical expenses. Present law limits deductions to the amount in excess of 5 per cent of taxable income; this would be dropped to possibly 3 per cent and health insurance payments made deductible.

3. The Federal government to take a more important role in rehabilitation of the physically handicapped.

4. Extension of social security to more than 10,000,000 additional persons. (The President's State of the Union Message did not mention mandatory coverage of physicians and others, but the Administration's bill carries this provision.)

5. Continuation of medical care for military dependents, but the message does not give any detailed recommendations.

6. Broadening of present Hospital Survey and Construction Act (Hill-Burton) to aid in development of facilities for the chronically ill, diagnostic centers, rehabilitation facilities, nursing homes.

## What the President Said on Medical, Health Issues

Following are excerpts from President Eisenhower's State of the Union message. They are points of interest to the medical profession.

### SOCIALIZATION OF MEDICINE

"I am flatly opposed to the socialization of medicine. The great need . . . can best be met by the initiative of private plans. But it is unfortunately a fact that medical costs are rising and already impose severe hardships on many families. The federal government can do many things and still avoid the socialization of medicine."

### RESEARCH

"The federal government should encourage medical research in its battle with such diseases as cancer and heart ailments, and should continue to help states in health and rehabilitation."

### HILL-BURTON PROGRAM

"The present . . . act should be broadened to assist in the development of adequate facilities for the chronically ill . . . of diagnostic centers, rehabilitation facilities and nursing homes."

### REINSURANCE OF HEALTH PLANS

"The war on disease . . . needs a better working relationship between government and private initiative. . . . A limited government reinsurance service would permit the private and non profit insurance companies to offer broader protection to more of the many families which want and should have it."

### REHABILITATION

"The program for rehabilitation of the disabled especially needs strengthening. . . . This program presently returns each year some 60,000 handicapped individuals to productive work. Far more disabled people can be saved each year . . . if this program is gradually increased."

### MILITARY DEPENDENTS

"Pay alone will not retain in the career service . . . the necessary numbers of long-term personnel. I strongly urge, therefore, a more generous use of other benefits important to service morale. Among these are more adequate living quarters, and medical care for dependents."



## MEDICAL TAX DEDUCTIONS

" . . . we propose more liberal tax treatment for dependent children who work, for widows or widowers with dependent children, and for medical expenses."

## VETERANS

"The internal reorganization of the Veterans Administration is proceeding with my full approval. When completed, it will afford a single agency whose services, including medical facilities, will be better adapted to the needs of those 20 million veterans to whom the Nation owes so much." (There was no further reference to VA in the address.)

## SOCIAL SECURITY

"I ask that this extension (to 10,000,000 more persons) soon be accomplished. This and other major improvements . . . will bring substantial benefit increases and broaden the membership of the insurance system, thus diminishing the need for Federal grants-in-aid . . ."

## Health Bills Submitted to House

On the opening day of Congress four health bills were submitted by Charles A. Wolverton (R-New Jersey), chairman of the House Committee. These were:

HR6949—to set up a federal reinsurance program for voluntary non profit plans enabling them to cover catastrophic illness without jeopardizing their reserves.

HR6950—to permit U. S. loans to non profit health associations for the improvement of facilities and equipment.

HR6951—to amend the Hill-Burton Act to provide mortgage-loan insurance for the encouragement of private capital investment.

HR6952—a tax law amendment to permit deduction up to \$100 a year from gross income of premiums paid into health care plans.

## Senator Purtell Takes Over Health Subcommittee Chairmanship

Physicians in Connecticut will watch with unusual interest the course of President Eisenhower's health bills through the Senate now that William A. Purtell of West Hartford is chairman of the health

subcommittee of the Labor and Public Welfare Committee. As such he will be prime contact man and will preside over such public hearings as may be held. It is Senator's belief that a very comprehensive program on health will be developed this year.

## The Low Health I.Q.

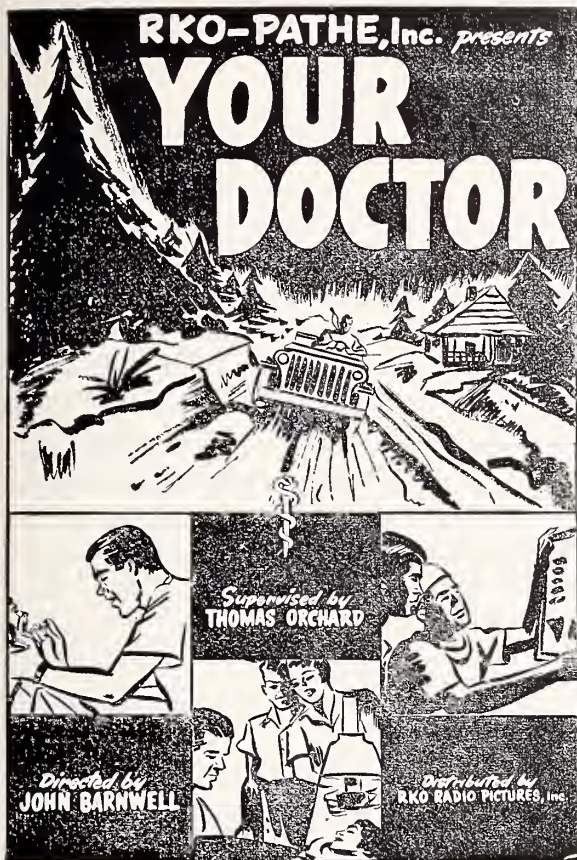
At the annual meeting of the American School Health Association meeting in conjunction with the American Public Health Association in New York City recently, a survey which was carried on by thousands of individuals was outlined by Dr. H. F. Kilander of New York University. Health knowledge is low for the American people. The survey of the health knowledge of the American people in the last twenty years shows that few individuals have sufficient knowledge to be able to act wisely in their personal needs.

In the survey it was shown that only about one-half of the public knew enough about nutrition to select a balanced meal in a cafeteria; one-quarter of the public believe that there is some truth to fish being a brain food; nearly half of those tested believe that communicable diseases can be inherited; about half still hold that tuberculosis is one of the diseases which may be inherited; only one-third realize that the lower death rate of today is primarily due to the prevention of infant deaths rather than to the prevention of adult deaths.

Participation in the planning for health activities is the best method of health learning, therefore it is a good sign to note the increased emphasis in the participation of health work by the laymen on Health Councils.

## TB Association Selects Several Doctors

Cole B. Gibson of Meriden was reelected a vice-president of the Connecticut Tuberculosis Association at its annual meeting recently and W. Haviland Morriss of Wallingford was reelected assistant treasurer. R. C. Edson of Cedarcrest Sanatorium became one of the new members of the executive committee and Hugh B. Campbell of Norwich, Stanley H. Osborn of Hartford, and Leonard Parente of Hamden were reelected to the board of directors. Winston C. Hamsworth of Willimantic was elected to the board of directors to serve his first term of two years.



Produced by Louis de Rochemont with the assistance of the American Medical Association, the documentary film, "Your Doctor," is now available in a 16 millimeter version for schools, churches, clubs and civic organizations.

This fifteen-minute sound film tells the story of Dr. George Bond's North Carolina mountain clinic, of how medical students are trained and of the relationships between physicians and their medical societies.

A copy of the film may be borrowed by any community organization without charge other than that for postage and insurance.

Physicians can help advance this educational program by calling the film to the attention of organization leaders. The booking coupon on this page may be used to reserve the film.

Connecticut State Medical Society  
160 St. Ronan Street  
New Haven 11, Connecticut

Please reserve a 16 mm. print of YOUR DOCTOR for our group

\_\_\_\_\_  
Name of Organization or School

☐ If film is not available as requested  
please schedule for first open date.

\_\_\_\_\_  
Date to be Shown      Alternate Date

ADDRESS TO WHICH FILM IS TO BE SENT

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
Zone

\_\_\_\_\_  
State

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title



## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold J. Bergendahl, Norwich

James C. Canniff, Torrington  
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Harry C. Knight, Middletown

John O'L. Nolan, Hartford  
James H. Root, Jr., Waterbury  
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### Connecticut TV Committee for Health Education Organized

A Connecticut committee is being organized to develop authentic health information programs for television audiences.

To be known as the Connecticut TV Committee for Health Education, the organization includes as its first members representatives of seven statewide health agencies and four television stations.

Chester S. Bowers, director of public health information, Connecticut State Department of Health, was elected coordinator of the committee at a recent meeting and subcommittees are now being formed to produce a series of health programs in cooperation with television stations.

Other charter members of the new committee and the organizations they represent are Robert I. Wakeley, Connecticut Division, American Cancer Society; Horace A. Brown and Norman Delisle, Connecticut Heart Association; Leo J. Conley, Jr., and Milton Geyer, Connecticut State Department of Health; Wells Cunningham and William B. Parsons, Connecticut Public Health Educators; James A. Hanaghan, M.D., Connecticut State Tuberculosis Commission; James G. Burch, Connecticut State Medical Society; Miss Ann Switzer and James B. Donnelly, Connecticut Tuberculosis Association; David Harris, Elm City Broadcasting Corporation, New Haven; Carl Flower, New Britain Broadcasting Company; Wallace King, WATR-TV, Inc., Waterbury; and Wallie Dunlap, Southern Connecticut and Long Island Television Co., Inc., Bridgeport.

As outlined in recently adopted articles of organization, the purpose of the committee will be "to provide Connecticut television station managements and official and voluntary health agencies with a clearing house for programs of authentic health information on a public service basis."

The committee will function as both a planning and production agency. Membership is open to state-

wide health agencies active in health education, with a qualified staff member to assume responsibility for producing television programs assigned on a rotation schedule by the full committee.

By thus pooling the work of experienced personnel in the various member organizations, it is anticipated that a well integrated series of health education programs can be brought to television viewers as a continuing public service. All programs will be produced in accordance with established codes of ethics as observed by physicians, nurses and other health personnel, and the National Association of Radio and Television Broadcasters.

Currently a number of health agencies are struggling with the complexities inherent in television productions. It is pointed out that the operating procedures of the new committee will be aimed toward reducing these problems for member organizations.

The committee's programming schedule will permit members to share responsibility for producing programs on any health subject, in addition to those directly connected with their organization activities. It is also stipulated that no program may be produced by the committee which includes a fund-raising appeal. However, this restriction refers only to committee productions and would not affect the development of such independent programs by member agencies.

### New Jersey Society to Improve Emergency Plans

The Public Relations Committee of the Medical Society of New Jersey is initiating a program to improve emergency medical coverage throughout the State in cooperation with local medical associations.

The project is to be set in motion in each county by a local committee on public relations, assisted by a similar committee of the Woman's Auxiliary, in

accordance with the following outline of purpose:

"Each county society public relations committee . . . will carry through a threefold program of (1) evaluation, (2) reconstruction, and (3) education, to culminate in the effective mutual cooperation of organized medicine and the general public for better medical care."

Emergency call plans currently in operation will be evaluated to determine the degree of satisfaction which they afford physicians and the public as the first step in the program. Based on this information, action will be taken to reconstruct each plan to eliminate duplication and improve its operation.

When the reconstruction phase has been accomplished, the project calls for a campaign of education to adequately inform physicians concerning their role in the program and to better acquaint the public with the type of service offered and how every resident can cooperate to assure efficient operation.

Guideposts for 1954 Public Relations Activities

A three dimension approach to the development of medical PR programs is proposed in the January issue of *PR Doctor*, published by the Public Relations Department of the American Medical Association.

The three dimensions are stated as "policy, program and promotion," and the importance of vigorous action in all three fields is stressed as highly important for the strengthening of programs to reach goals set for 1954.

Only when a strong public relations policy exists can a medical association develop a sound program of activities which will achieve the results anticipated when implemented by publicity and other methods of promotion, the article points out.

Life Insurance Fund Grants to Yale

The Life Insurance Medical Research Fund, organized in 1945 by a group of U. S. and Canadian life insurance companies for the support of medical research, has brought out its eighth annual report covering the year 1952-53. We find by this report that Yale University School of Medicine has bene-

fitted very materially as the following research list will show:

To Dr. Frank D. Gray, Jr. in circulatory changes in heart and lung disease, \$10,495.

To Dr. Levin L. Waters in the development of arteriosclerosis, \$42,360.

To Dr. John R. Paul in the nature of rheumatic fever, \$78,750.

To Dr. D. D. Bonnycastle in plasma constituents which improve heart action, \$10,500.

To Dr. Ruth Whittemore in congenital heart disease, \$10,395.

A research fellowship, postdoctoral, was awarded to Jack P. Green, PH.D., of New Haven for a study of the action of dicumarol and another to Anton N. Lethin, Jr., M.D. of New Haven for a study of neuronal polarization potentials.

THE DOCTOR'S OFFICE

Edward S. Bundy, M.D. announces the opening of an office for the general practice of medicine and surgery at 9 Center Street, Southington.

Alexander Bellwin, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 65 South Street, Stamford.

R. Harrison Freedman, M.D. announces the opening of an office for the practice of head and neck surgery and medicine, and plastic and reconstructive surgery at 1231 Summer Street, Stamford.

Isao Hirata, Jr., M.D. announces the opening of an office for the practice of surgery at 1187 Chapel Street, New Haven.

Bernard Klein, M.D. announces the opening of an office for the general practice of medicine at 219 West Main Street, Meriden.

Robert F. Newton, M.D. announces the opening of an office for the practice of pediatrics at 1960 Whitney Avenue, Hamden.

W. Leslie Smith, M.D. announces the reopening of his office for the practice of medicine limited to infertility, gynecological endocrinology and minor gynecology at 85 Jefferson Street, Hartford.

Joseph Zimmerman, M.D. announces the opening of an office for the general practice of medicine at 219 West Main Street, Meriden.



## MILITARY AFFAIRS

### COMMITTEE ON MILITARY AFFAIRS

COLE B. GIBSON, Meriden

STANLEY B. WELD, Hartford

HAROLD SPEIGHT, Middletown

### Commission Again Proposes UMT; No VA Rights for Trainees

For a second time, the National Security Training Commission is proposing that universal military training be adopted. In general the recommendations are similar to those the commission made two years ago, when the House rejected the plan, 236 to 162. In its new report, the commission reasons that with the Korean war ended, the supply of young men is sufficient for both UMT and the regular draft. Whether a man would be taken up by the regular draft or enter UMT would be determined by lot. The drafted man would have two years of active service, and six years' reserve obligation. The UMT enrollee would have six months' training, followed by seven and one-half years' reserve obligation. Of medical interest are the following commission proposals:

1. UMT veterans' problems would not be handled by Veterans Administration; injuries or sicknesses incurred during training would be compensated for under the Federal Employees Compensation Act, and the men would consult their own private physicians and be cared for in private hospitals following discharge. (This is in line with recommendations made by the AMA in 1951.)
2. The training agency—Army, Navy or Air Force—would be responsible for the medical care of the trainee during the six month period.
3. Premedical and other students could be deferred only until the completion of the school year. (AMA had recommended continuation of education, with UMT obligation deferred.)
4. No mandatory rehabilitation of boys found physically unacceptable for training, but a downward adjustment of physical and mental standards combined with "a more realistic matching of personnel characteristics to essential job requirements." (AMA also had opposed mandatory rehabilitation.)
5. Pre-induction examination to be handled by Selective Service. (AMA had recommended that pre-

induction as well as periodic examinations be given by private contract physicians on a fee basis.)

Early reaction to the UMT proposal on Capitol Hill indicated it probably would not be given much consideration by Congress this year. Among those who spoke out against it were House Speaker Joseph Martin and Chairman Dewey Short of the House Armed Services Committee.

### Presumption of Service Connection in Veterans Administration

The phrase "presumption of service connection" is a foundation stone of the present Veterans Administration medical care program. It explains in part the great increase in the rolls of VA service connected cases in the last few years. Once a presumption of service connection is accepted by the government, the veteran usually is entitled to exactly the same considerations as one who was wounded in battle or whose condition developed while he was in uniform. In addition to rating a top priority for full medical care—hospital, outpatient, and home town—the veteran with a "service presumed condition" is also eligible for financial compensation if his disability is found to be 10 per cent or more.

Thus there is the possibility of a veteran receiving a monthly check from the government as compensation for an illness, contracted after return to civilian life, that is being treated free by the Veterans Administration.

The war veteran whose case is strictly non service—where no connection can be shown with his active duty and where the particular disease or condition is not on the "presumptive" list—has a different status. Any treatment he receives must be in the hospital; he is not entitled to outpatient or home town care nor to compensation for his disability.

Under present law, the veteran is entitled to presumption of service connection during various periods of time following his discharge from service, the number of years allowed depending on the

particular disease or disability. In some cases his condition may be certified as service connected even if it appears as late as three years after his separation, and a bill now in Congress would raise one limit to seven years. The assumption is that any disease or condition on the list could be incurred in military service, then lie dormant or go undiagnosed for one, two, or in the case of tuberculosis, three years.

Although not every presumption of service connection is recognized as valid, if a contest is to be made the burden of proof is on the government; it must produce definite evidence that the disease or condition could not be related to military service. In certain cases the presumption is conclusive, denying the government any opportunity to challenge the claim even if it so desires. (In this report all categories will be regarded as rebuttable, unless they are identified as conclusive.)

When a presumptive case is accepted as service connected, the veteran is taken off the hospital waiting rolls and almost immediately starts his treatment. His care is expedited exactly as though he were reporting for treatment of an old battle wound. His disability becomes service connected, without qualifications. As of October 1, 1953, the Veterans Administration reported only seven of the 17,113 waiting cases were listed as service connected.

The number of presumptive service connected cases must be high, considering the many diseases listed as eligible for this consideration, but the total can only be guessed at. A Veterans Administration spokesman said no record is kept of rejected claims in this category, nor does VA make any breakdown to show the percentage qualifying as service connected under the various presumption laws.

#### CHRONOLOGY OF IMPORTANT LAWS AND REGULATIONS

1921—Congress first officially recognized the concept by authorizing service presumption for all tuberculosis and psychosis cases. The cases would have to be diagnosed within two years after discharge from service.

1923—Congress extended the two years to three.

1924—The World War I Veterans Act broadened the concept of presumptive service connection in this manner: Any veteran shown to have certain specified diseases or conditions prior to 1925 would be presumed to have incurred the disability during his World War I service. Claims for active tuberculosis were conclusive, not subject to challenge by

the government. Diseases qualifying as presumptive service connected were expanded to include paralysis agitans, encephalitis lethargica, and amoebic dysentery in addition to tuberculosis and neuropsychiatric conditions, provided they developed 10 per cent or more of the disability. However, the law specified that there would be no presumptive diseases after January 1, 1925.

Interim developments—During the period from 1921 until 1948 (see below) the chief of the Veterans Bureau and of his successor, the Veterans Administrator, issued a number of regulations designed to broaden opportunities for veterans to qualify as service connected disabled via the presumptive route. In 1921 "constitutional chronic diseases" were designated as presumptive, with a one year time limit. Subsequent memos from the medical director specified that chronic diseases included such conditions as arteriosclerosis, leukemia, diabetes, arthritis, cancer, heart conditions, and a few others, but did not take in acute medical conditions.

1933—During the first month of President Franklin D. Roosevelt's first term the Economy Act repealed all presumptive benefits that had been added by laws and regulations since 1921. But the Economy Act also authorized the President to issue regulations covering veterans' care. One of the first of these reinstated chronic diseases, if 10 per cent or more disabling, with a one year limit, but the diseases were not defined.

1934—One year after the Economy Act, Congress restored to the rolls certain presumptive cases which had qualified under the 1924 act but had been eliminated in 1933. In brief, it reestablished any case that had or could qualify under the 1924 act, subject to more restrictive official dates for the beginning and ending of World War I.

1948—On June 24, 1948, the 80th Congress passed its Public Law 748. It is the basic law to which subsequent amendments have been and are now being made. What the law did: 1. It specifically listed in the statute 23 chronic diseases that had been declared presumptive by the President pursuant to the 1933 Economy Act. (Of the tuberculosis types, only active tuberculosis was included.) 2. It added 16 tropical diseases to the list. 3. It authorized the VA administrator to add more chronic diseases and to include disorders or diseases resulting from the therapy administered in connection with the tropical diseases.



1950—Congress amended Public Law 747 (above) to allow a three year presumptive period for pulmonary tuberculosis, rather than the one year specified for all diseases, providing the disability was 10 per cent or more. Congress at this time also voted to apply the presumption of service connection to all veterans of the Spanish-American War, the Philippine Insurrection and the Boxer Rebellion in an unusual way. It voted to give presumption of service connection to these veterans for any type of outpatient care. Over the years they had benefitted from laws extending other medical and hospital care benefits.

1951—Congress extended the presumptive period for multiple sclerosis to two years, if disability is 10 per cent, and extended the time for active psychosis, which had been one year for full medical benefits, to a two year conclusive presumption for hospitalization only.

1953—Congress again amended Public Law 748 to extend the three year period for pulmonary tuberculosis to include all types of active tuberculosis.

#### PENDING BILLS ON PRESUMPTIONS OF SERVICE CONNECTION

A number of bills on presumption of service connection hold over from the last session and will be awaiting Congress when it reconvenes in January. Each would liberalize the presumptive period for a particular disease when the disability is 10 per cent or more. The proposals would:

Extend the presumptive period for all chronic and tropical diseases from one to three years. S601 by Senator Sparkman (D—Alabama), HR25 by Mrs. Edith N. Rogers (R—Massachusetts), and HR 1573 by Rep. Laurie C. Battle (D—Alabama).

Extend period to three years for multiple sclerosis or psychoses, S762 by Senator Martin (R—Pennsylvania), and HR33 by Mrs. Rogers.

Extend period for malignant tumors from one to two years, HR45 by Mrs. Rogers.

Extend period for amyotrophic lateral sclerosis from one to two years, HR3070 by Rep. Peter J. Frelinghuysen (R—New Jersey).

Extend three year period for tuberculosis to seven years, HR2097 by Rep. Harold Hagen (R—Minn.).

Make the three year period for active pulmonary tuberculosis and the two year period for multiple

sclerosis conclusively presumptive (could not be contested by government). HR5012 by Rep. Eugene McCarthy (D—Minnesota).

#### DISEASES ENUMERATED IN PUBLIC LAW 748

The following diseases are to be regarded as presumed service connected, if manifest within a year after separation:

Chronic diseases: anemia, primary; arteriosclerosis; arthritis; bronchiectasis; calculi of the kidney, bladder, or gallbladder; cardiovascular-renal disease, including hypertension, myocarditis, Buerger's disease, and Raynaud's disease; cirrhosis of the liver; coccidiomycosis; diabetes mellitus; endocarditis; endocrinopathies; epilepsies; Hodgkin's disease; leukemia; nephritis; osteitic deformans; osteomalacia; organic diseases of the nervous system, including tumors of the brain cord or peripheral nerves; encephalitis "lethargies" residuals; scleroderma; tuberculosis, active; tumors, malignant; ulcers, peptic (gastric or duodenal); and such other chronic diseases "as the Administrator of Veterans' Affairs may add to the list."

(As noted above in the chronology, subsequent Congresses extended the period for multiple sclerosis to two years and for tuberculosis to three years, made all forms of tuberculosis eligible, and extended the one year rebuttable presumption for active psychosis to a two year conclusive presumption, but limited to hospitalization.)

Tropical diseases: black water fever; cholera; dracontiasis; dysentery; filariasis; leprosy; leishmaniasis; loiasis; malaria; onchocerciasis; oroya fever; pinta; plague; schistosomiasis; yaws; yellow fever and others.

Regarding tropical diseases, the law also states that ". . . the resultant disorders or diseases originating because of therapy administered in connection with such diseases, or as a preventive thereof, shall be accorded service connection when shown to exist one year after separation from active service or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service. Nothing in this paragraph shall be construed to prevent service connection for any disease or disorder otherwise shown by sound judgment to have been incurred in or aggravated by active service."

## FROM OUR EXCHANGES

Garnett and Morrison have published a summary of collected cases in the literature of primary carcinoma of the gallbladder together with an analysis of the experience at the Hartford Hospital with 97 cases ("The Link Between Stones and Carcinoma of the Gallbladder," *Hart. Hosp. Bull.* VIII:3). The authors found primary carcinoma of the gallbladder sixth among digestive organs; the percentage in consecutive hospital admissions less than 0.5, in consecutive gallbladder operations 1.12, in consecutive autopsies 0.43, in consecutive autopsies with cancer 4.53; the percentage of gallstones in all adults 10 to 25, of gallstones in primary carcinoma of the gallbladder 73.2, in secondary carcinoma of the gallbladder 8 to 25; and the percentage of calculous gallbladders which will develop carcinoma 2.

These figures, as the authors point out, show that cancer of the gallbladder is a rare disease and that, in general, prophylactic measures are indicated only when the incidence of exposure is high, protection is certain, and the particular preventive procedure is harmless. This disease constitutes less than 1.5 per cent of all lesions of the gallbladder found at the operating table. Their final conclusion: "The expectancy of future mechanical trouble, future cardiovascular complications, and the possibility of development of cancer all argue for selective prophylactic cholecystectomy in patients with asymptomatic gallstones who are reasonable surgical risks."

\* \* \* \*

"Bacterial Allergy" is the subject of a guest editorial by Swineford in the *Virginia Medical Monthly*, August 1953. (80:8.) The idea is stressed that bacterial allergy "is an important and little explored fact of medicine." Infectious asthma is a familiar result of bacterial allergy. The patient develops a respiratory infection and then wheezes. The wheezing continues until, but stops promptly after, the infection is controlled.

It is commonly believed at the present time that bacterial allergy plays a major role in the morbidity of tuberculosis, in the pathogenesis of rheumatic fever and in infectious asthma. The allergic response to bacteria takes the form of not only atopic syndromes, but also occurs just as typically as an

eczematous "Ids," acute anaphylaxis or a delayed tuberculin type reaction. There are a wide variety of antibodies in bacterial allergy (antistreptolysins, antifibrinolysins, agglutinins, precipitins, antitoxin, complement fixers, etc.).

Skin tests as a means of identifying the organism responsible for asthma are disappointing. The average human being reacts to many bacterial extracts that do not give him asthma. The most that can be claimed in favor of skin tests is that they give a diagnostic lead but not a positive diagnosis. We must sadly confess that, while much is known about bacterial allergy, it nevertheless remains true that more is unknown. Research and education find in this field a challenge that is being accepted. The author expresses a confident hope that the future will show progress which in time may be at least comparable to the progress made in other fields of the medical sciences.

Swineford finally points out that the treatment of bacterial allergy has not been standardized. Bacterial antigens cannot be avoided, though they may often be removed by surgery or by antibacterial agents, with relief of symptoms. Treatment with bacterial antigens is empirical and is often but unpredictably, effective.

\* \* \* \*

A recurring discussion in many hospitals is that of the practicability of diagnosing and treating borderline psychiatric patients in the wards of a general hospital (Crocket, *Brit. Med. Jour.* 4828). The author admits that the care and treatment of such patients in the wards of a general hospital would be in the nature of a revolution and that the adoption of such a plan would inevitably mean the bringing of the present staff of mental hospitals into the wards of the general hospital. He recognizes that many borderline patients in the general hospital would never enter a mental hospital, but on the other hand he can discover no natural clinical cleavage between those patients who do not and those who do end in a mental hospital. The truth of the matter is that experience shows that there are many similarities in pathology and the treatment of the two groups.



He considers that treatment of borderline psychiatric cases in the general wards should be regarded as a provisional arrangement, pending the establishment of specially constructed and equipped psychiatric clinics within the general hospital. It appears to the author the better part of wisdom to treat all voluntary patients and all borderline patients in a general hospital rather than in a so-called mental hospital. As a matter of practice most approved institutions for the mentally disturbed seek to approach this ideal by means of an observation ward whose special function is that of classification.

The whole matter of the care of the borderline psychiatric patient should be explored in a purposeful, experimental way. The questions to be answered are, first, how many patients can be treated successfully in the general hospital, and, secondly, what special administrative arrangements and regimes would be necessary for furthering the integration of psychological and physical medicine.

\* \* \*

Old age has its vices ("Old Age and the Vices," Cecil. *Geriatrics*, I:9). Even under the best of conditions the elderly have few compensations. The leisure that allows reading, meditation and travel cannot be indulged all the time. A couple of cigars and a cocktail in the evening can hardly be labeled as a sin. We must not allow ourselves to forget that different standards of conduct apply to elderly people than to the young on the simple grounds that the human machine will stand for a lot of nonsense during the early decades of life, but that it will put up with much less abuse in the late decades.

Of the casual vices over indulgence in alcohol is perhaps the most important. Alcohol is not contraindicated for the aged, but it is a well proven fact that the lethal dose of alcohol is in inverse proportion to age. Old people commonly discover for themselves that temperance is the best policy and gradually reduce their daily intake to the point where no unpleasant effects are produced. It might be added at this point that alcohol is an important therapeutic agent in coronary disease, for nothing quite equals it as a vasodilator. The pain of coronary insufficiency and sclerosis is relieved by alcohol. Elderly people rarely become alcoholics unless the habit of drinking has existed many years previously.

Tobacco in these days affords a more controversial field for discussion than does alcohol. The author expresses interest in the fact that many of his

physician friends have given up the use of tobacco. In part this is ascribed to the irritation that tobacco causes in the upper respiratory tract, but an additional factor of unassessed importance is the psychological one of the many reports regarding the effects of tobacco on the blood vessels and the incidence of lung cancer in smokers as contrasted with non smokers. There is one individual who cannot smoke, regardless of his age, and that is the patient with thromboangiitis obliterans. Having due regard to all the objections to the use of tobacco, Cecil considers it the part of wisdom to allow the aged to use tobacco in moderation. Like alcohol, tobacco constitutes one of the few pleasures available to the elderly.

Many elderly patients have difficulty in getting to sleep at night and indulge themselves with sleeping tablets. Cecil favors the habit to the extent of 50 to 100 mg. of one of the quick acting barbiturates nightly. The barbiturates are not habit forming; and they do not affect the mind or the intelligence of elderly people unless taken in doses so large as to cause drowsiness during the day following ingestion. A tolerance for barbiturates is rarely established so that the same dose is effective for an indefinite period of time.

Gluttony or the vice of overeating accounts for the prevalence of obesity in the aged. It goes without saying that obesity introduces the aged to many hazards, such as the extra burden on the heart, the limitations on physical activity, the disposing cause of diabetes and osteoarthritis, etc.

Overwork, unless coupled with worry, is not an important vice of elderly people. They do not die from overwork.

Idleness is a vice that many elderly people enjoy with no apparent harm to their health. However, the sudden release from responsibility and a well ordered daily routine has a profound effect on patients' morale, and this in turn affects the whole physical equilibrium. There are too many casualties among retired executives—more than would be expected in the natural course of events.

For the elderly advice is offered that in sexual matters they should not allow ambition to conquer moderation. We hear much in these days about the waste of penicillin. The author wonders if the waste of testosterone is not almost comparable.

Let the old man have these things—but in moderation.

"Bacterial Resistance to Antibiotics" is the subject of a brief discussion by Selbie in *The Practitioner*, (1023:171). The first unfavorable effect is that bacteria may acquire resistance during the treatment of a particular case, making further treatment with the drug ineffective. This rarely occurs with penicillin and the sulphonamides. It does occur often with streptomycin, and with chloramphenicol, aureomycin and terramycin. The second unfavorable effect lies in the possibility that the widespread use of chemotherapeutic agents may lead to resistant bacteria becoming so prevalent in the general population that the drug will be rendered useless. All the available evidence indicates that the general practitioner can use the sulphonamides and penicillin for infections for which they are indicated without fear of creating resistance in the infecting organisms or increasing the prevalence of resistant infections. All the other antibiotics should be used with caution.

\* \* \* \*

The clinical toxicity of terramycin has received much and rather confused attention from the medical profession during the past few years. Miller and Walker report on their experience with the prolonged administration of terramycin to 70 tuberculous patients. (*New Eng. Jour. Med.*, 249:12). Each patient received 5 Gm. of terramycin daily in combination with 2 Gm. of streptomycin every third day. The drugs were given for one hundred and twenty days. This is a larger quantity of these drugs over a longer period of therapy than most clinicians have had experience with up to the present time.

Gastrointestinal-tract irritability, with resulting anorexia, nausea and vomiting were the only toxic manifestations that were noticed during the period that terramycin was administered. The irritation was never serious and it was never necessary to discontinue the drug during the four months period of administration, and in only four instances (5.7 per cent) was it necessary to reduce the dose of terramycin.

\* \* \* \*

Virginia, according to Gayle and Gee, Jr., is faced with an increasing problem of barbiturate addiction and attempted suicides using barbiturates (*Va. Med. Jour.*, 80:10). It is probable that this situation is duplicated in most of the states of the Union. The dangers involved in making the barbiturate drugs easily available to patients should receive serious attention, not only by the medical profession but also by the public at large.

Many suicide cases were rescued by means of the Reiter Electro Stimulator. This machine provides continuous electrical stimulation over as many hours as are required to arouse the patient.

"Why People Faint" is a question that has bothered most of us at one time or another (Warren, *G. P.*, VI:5). Dr. Warren explains that in most instances syncope results from transient inadequacy of blood supply to the brain. This may be due to cessation of cardiac activity (heart block, reflex cardiac standstill, carotid sinus syncope), to a fall in blood pressure (common faint, postural hypotension, carotid sinus syncope), and in the presence of no obvious circulatory changes (hysteria, hyperventilation, certain types of cardiac disease, brain disease). The cause of fainting can usually be ascertained by the taking of a careful history and a good physical examination. The treatment is naturally directed to the underlying cause of the fainting spell.

\* \* \* \*

"Is There Such a Thing as Soft Tissue Rheumatism?" (Holbrook, *G. P.*, VI:5). Dr. Holbrook considers that soft tissue rheumatism occurs more frequently than articular rheumatism. Classification is, however, unsatisfactory for the reason that little is known of its pathology or specific etiology. He adds that the most common types fit into a simple clinical grouping such as localized fibrositis (neck, shoulders, back, and various types of bursitis). The author believes that the main problem is that of separating these patients from those normal individuals that suffer from tension pains. The best results are obtained by gentle stretching and the use of cortisone or ACTH.



## LETTERS TO THE EDITOR

### Osteopathy in New York State

Connecticut Osteopathic Society

December 18, 1953

To the Editor:

On page 843 of your October 1953 issue appears an editorial captioned "The Osteopath—What is His Future?" The editorial is, we believe, a very fair report upon the presently existing relations between the medical and osteopathic professions in Connecticut. We cannot entirely agree with some of the opinions you express but it is not the purpose of this letter to contest them. We write to you purely in the interests of accuracy.

The first paragraph on page 844 does not cite the circumstances in regard to the practice of osteopathy in New York State quite accurately and, therefore, we offer the following information:

1. At no time has there been an independent osteopathic board in New York. The practice of osteopathy was legalized there in 1907, the enabling law providing that an osteopathic physician be appointed to the medical board, thus creating a composite (combined) board which would examine both medical and osteopathic candidates for license. The board has continued in this pattern to date.

2. The law further provided that both medical and osteopathic candidates would take the same examination under this one board and this process is still followed. However, despite taking the same examination successful osteopathic candidates were granted a license which did ". . . not permit the holder thereof to administer drugs or perform surgery with the use of instruments."

3. Between 1907 and 1939 there were repeated attempts by the osteopathic profession to obtain wider practice privileges, in keeping with the steadily improving standards of osteopathic education and training. Such attempts were fruitless until 1939.

In that year the education law was amended to provide ". . . that any person holding a license to practice osteopathy or any applicant for such license, who upon submission of proper credentials or by examination satisfies the regents that he has received sufficient instruction and training, may be

granted the additional right to use instruments for minor surgical procedures and to use anesthetics, antiseptics, narcotics and biological products . . ." The law made no provision for "extension of rights certificates" to those who qualified for them under the law. They were the result of the New York State Osteopathic Society's request of the Education Department that qualified osteopathic physicians be issued some sort of evidence, in addition to their regular license, which would indicate that they had met the requirements of the amended law. The great majority met the requirements and were issued the certificate.

The amended law further provided that, beginning in 1940, successful candidates for osteopathic licenses (those passing the regular composite board examination) would be licensed with these rights without further examination. This situation held until 1946.

4. In 1946 the education law was again amended, this time to effect a "parity" under the law between medical and osteopathic physicians. Those who had qualified under the 1939 amendment and those licensed after 1940 were "granted the right to practice medicine without limitations as defined by the statutes of the State of New York." Candidates for osteopathic licensure are today licensed to practice medicine and surgery in which the state includes the practice of osteopathy. Now, as in the past, the only way in which an osteopathic physician may become licensed in New York State is to pass the composite board examination (reciprocity excepted).

Up until 1946 the Medical Society of the State of New York was definitely opposed to any broadening of the practice privileges of osteopathic physicians. But when the 1946 amendment was under discussion prior to its submission to the legislature the Society announced that it not only would not oppose its passage but, in fact, favored its passage. There was no real opposition to its passage from any source.

This is a brief "history" of the practice of osteopathy in New York State. The above points have been verified by the secretary of the New York State Osteopathic Society and can be verified also by the officials of the Medical Society, the Board of Regents, the State Education Department, or other such authorities.

It is hoped that this letter, and the information it contains, will be of some help in bringing about a

better understanding between our professions—to the public good.

Very sincerely yours,  
W. John Field, D.O., President

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### Used Medical Journals Wanted

St. George's Mission Hospital  
Punalur, P. O., Travancore, South India

October 24, 1953

To the Editor:

I wish to inform you that the above hospital is a non profit organization situated in a hilly village and working among the poor labour classes of the locality and its suburbs. As good medical literatures are very few in this part of the world, a small library is started recently attached to the above hospital with the idea of collecting used Medical Journals, books, bulletins, reprints of articles and Transactions of Medical Societies from all available sources in foreign countries so that up-to-date knowledge in medical practice may be obtained.

Further Ayurvedic and Unani systems of medicine are very troublesome competitors to Allopathic system here and proper equipments and medical literatures are highly essential for the successful management of this hospital.

In the light of the above circumstances, I request you to kindly issue a News Note in your monthly Bulletin and also in your Society Medical Journal requesting the sympathetic members of your Society to send me their used Medical Journals with all available backward copies, medical books, reprints of articles and other useful medical literatures and also second-hand surgical instruments, medical appliances, laboratory equipments and gift parcels of drugs and patent medicines so that many of our poor patients may be directly and indirectly be benefitted by them.

This act of kindness and charity by the members of your Society will ever be remembered and lapse of time cannot wipe away from our memory.

Thanking you very much for all your valuable services.

Yours very truly,  
T. K. Thomas,  
Hon. Medical Superinendent

### Memories of Eugene O'Neill

The Gaylord Farm Sanatorium  
Wallingford, Connecticut

December 18, 1953

To the Editor:

My recollections are of an interesting youngster who was still searching for answers. Certainly he was always most appreciative and gave his period of rest on the porches of Gaylord much credit for starting him on his subsequent career.

Ever sincerely,  
David R. Lyman, M.D.

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### Dr. Wilson Elected President of Connecticut Health League

Dr. Charles C. Wilson, professor of health and education in the Department of Public Health, Yale University School of Medicine, was reelected president of the Connecticut Health League at the organization's annual meeting January 13 in New Haven.

Dr. Luther K. Musselman, New Haven, delegate to the League from the State Medical Society, and Dr. Ira Dow Beebe, Bridgeport, delegate from the Connecticut State Dental Association, were elected vice-presidents. Mr. Horace A. Brown, Hartford, executive secretary of the Connecticut Heart Association, was elected secretary-treasurer of the League.

### Hartford Hospital Staff Honors Dr. Wilmar Allen

At its annual dinner on January 14 the Medical and Surgical staff of the Hartford Hospital presented Dr. Wilmar M. Allen with a handsome silver tray. The presentation was made by the president of the staff, Hartwell G. Thompson, "in recognition of his service to this hospital, this staff, and this community." Dr. Allen has been director of the Hartford Hospital for the past 18 years and for 10 years prior to that was the pathologist and director of the Hall-Wilson laboratory at the hospital. He is retiring this month to be succeeded by Dr. T. Stewart Hamilton who was also an honor guest at the dinner. About 200 including members of the staff and the Board of Directors attended the dinner.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Dewey Katz, Hartford*

*President-Elect, Mrs. Newell W. Giles, Darien*

*Second Vice-President, Mrs. Winfield Kelly, Norwich*

*Recording Secretary, Mrs. Walter Nelson, Cromwell*

*Corresponding Secretary, Mrs. Stevens J. Martin, Hartford*

*Treasurer, Mrs. Norman J. Barker, Collinsville*

### AUXILIARY ART-MUSICALE IN HARTFORD

The Connecticut Physicians Art group will hold its second art-musicale at the Avery Memorial in Hartford on Sunday, March 28. The program will include showing of the art exhibit from 5 to 6 P. M., cocktails 6 to 6:30 followed by a buffet supper, and a musicale by physicians and physicians' wives at 8 P. M.

Reservations will be limited to the first 200 applying and may be made through Mrs. David O'Keefe, 32 Sesson Avenue, Hartford at \$3.50 per person.

### Civil Defense

The following letter was sent to Mrs. Dewey Katz from the National Chairman of the Committee on Civil Defense, Woman's Auxiliary to the AMA.

Dear Mrs. Katz:

Thank you so much for your splendid cooperation on the panel on Civil Defense at the November Conference. You made an excellent contribution and many have referred in a complimentary way to the panel.

When we last conversed I promised to tell you something about how the Wayne County (Detroit) Auxiliary had worked with the Medical Society.

One of the things which I feel brought the Auxiliary and the doctors into a closer understanding of the problems was the fact that at the onset of the Medical Society's plans for Civil Defense they asked that three representatives be assigned by the auxiliary to attend the meetings of their committee. Being one of these three I know that it gave us a better idea of the problems the men were having to face and also an opportunity for us to let the men know that we as an Auxiliary were standing ready to assist when they needed us.

One of the first calls was when the Civil Defense Committee was finding it almost impossible to get the doctors to go to be registered and receive their

cards, etc. The women took over. Thirty of us became notaries so that we would be in a position to notarize the registration cards. We then set up teams of three members—a notary, typist and another person—and set aside a certain week in which we aimed to contact all the 2,400 members of the Wayne County Medical Society. We went to the hospitals and set up our team. In my own instance we were stationed in the doctors' cloakroom where we got the doctor either as he came in or went out. As soon as he was registered he was given a little ribbon to wear so that he would not be bothered by other "teams" either at that hospital or any other during the week. A followup later helped to get the ones who had not been registered earlier. Two things were accomplished: the doctors were registered and they were made to feel aware of the keen interest in Civil Defense among the wives; they are not so apt to be apathetic about something if they feel the women think it is important.

Then the problem arose of getting the doctors to the meetings of civilians in the communities. These meetings finally bogged down because the doctors did not show up to "teach." One of the weak spots was that there was no "follow through." If a doctor did not show up, there was no one to call him to find out why or to see if he intended to come the next time. The men at the head of it did not have

the time to do this. So when the Civil Defense department wanted to reactivate several of the "pilot stations" they called on the women. That meant contacting lay persons who had at one time indicated a willingness to learn how to help in civil defense. The women made over 2,000 phone calls. They also provided an administrative assistant to help at each center to keep records and follow through. In one instance a personal friend of mine took this job and her husband (who had not been active before) took charge of the medical part of the program. They were able to work as a "team." A common interest proved to be the incentive for this doctor-wife team.

Perhaps our best answer to the problem of how to stimulate an interest in the Civil Defense program among the doctors is to first interest the doctors' wives. It is much easier to arouse an interest in something if you know something about it yourself. When we can talk intelligently on a subject we are much more apt to talk convincingly.

I hope my comments may have brought you a little information. Again, thanking you, I am,

Most sincerely,

Kathleen Mackersie

Mrs. William Mackersie

### Vaccine Validity Study

A nationwide study to determine the effectiveness of a polio vaccine in preventing paralytic polio will get underway during the week of February 8, 1954 and ending June 1, 1954. During that time 500,000 to 1,000,000 school children of the second grade will have taken part in this study. Participation will be on a voluntary basis with the consent of the child's parents or legal guardians. The study will be conducted by the National Foundation for Infantile Paralysis with local health officers in charge. Local physicians will administer the injections.

Auxiliary members will be called upon to assist the Foundation's 3,100 volunteers in organizing and manning the study in local areas. The American Medical Association feels that Auxiliary members can make a very worthwhile contribution to this important and meritorious project by participation as individuals on a local level with the group who are serving as volunteers in this study.

### County News

#### HARTFORD COUNTY

On January 19 the Auxiliary held a card party at Centinal Hill Hall, G. Fox & Co., to raise money for the American Medical Educational Foundation.

Mrs. James A. Hanaghan is the new chairman of Nurse Recruitment. Mrs. Francis J. Braceland is Mental Health chairman.

#### NEW LONDON COUNTY

For February there are plans to run a supper dance for members and their husbands. Also in February there will be a membership tea, with emphasis on the new members. The program will feature a musical performance and art exhibit by members.

### Dr. Ralph Richardson Honored

Ralph Richardson who has been president of the medical and surgical staff of the Bristol Hospital for the past 28 years was tendered a dinner at the hospital on January 13. Present were members of the active and consultant staffs and the directors. But for the fact that Dr. Richardson had to get up from a sick bed where he had been confined for a few days, it was a gala occasion. Mr. Fuller Barnes presided in his usual masterful manner and his successor, Charles T. Treadway, Jr., the new president of the hospital, offered felicitations to Dr. Richardson. Lawrence Frost of Plainville regaled the audience with tales of Army experiences with Ralph in World War I in addition to many quasi historical facts of Ralph's earlier years. Arthur Landry added a serious touch to the occasion and Mr. Towle, the genial superintendent, read letters from Bill Hanrahan and Tom Murdock.

Ralph Richardson has been a leader in Bristol medicine and in the development of the Bristol Hospital. Hyman Winters, his successor as chief of staff, paid tribute to the friendly helpfulness Ralph has always afforded the younger men. His influence has reached beyond the local community for many years, notably since his term of office as president of the Hartford County Medical Association.

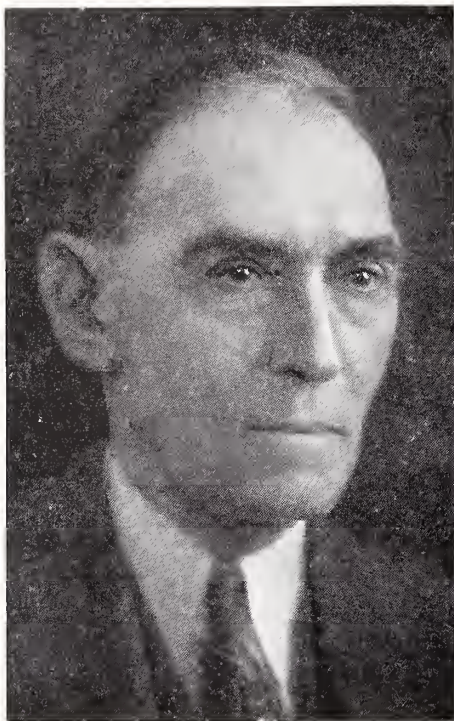
The Bristol Hospital Medical Society presented Dr. Richardson with several fine gifts. Physicians were present from Waterbury, New Britain, Hartford and New Orleans.



## OBITUARY

Oran A. Moser, M.D.

1871 - 1953



Dr. Oran A. Moser, devoted family doctor for more than fifty years, died at his home in Rocky Hill on November 10, 1953 after an illness of three months.

Dr. Moser was born in Patterson, Iowa on July 1, 1871, the youngest of eleven children. While attending high school he worked as a male nurse in a private Nebraska hospital which was moved to Waterbury, Connecticut in 1897. Dr. Moser came to Connecticut at that time and later entered Yale Medical School, graduating in 1902. He then served as Resident Physician at the State Prison in Wethersfield, following which he began his practice in Rocky Hill on August 1, 1903.

His life was one of unrelenting service to his fellow men and faithful devotion to the sick. As Health Officer from 1918 to October 1952 he guarded his community with constant care against all public hazards. He was a deacon of the Rocky Hill Congregational Church from 1914 to 1953. In 1921 to 1923 he served his town in the State Legislature.

Through his efforts the State obtained property on which now stands the State Veterans Hospital. He was also Medical Examiner from 1918 to 1952. He was a past member of the Rotary Club of Wethersfield and served as vice-president of the Cromwell Savings Bank.

Dr. Moser was attending physician to the Veterans Home in Rocky Hill until the Veterans Hospital was moved from Noroton to Rocky Hill. In 1933 he served the Hartford County Medical Association as its president. During both World Wars he served as an examining physician for draft boards of Hartford County.

The esteem and affection of his townspeople have been manifested by their testimonial dinner in 1944, by a public tribute to him in his beloved church in July 1953 and by the naming of one of their newest schools the Dr. Oran A. Moser School. A feeling of personal loss is borne by his entire community.

Besides his wife, Dr. Moser leaves two sons, Oran A. Moser, Jr. of Newington, Dr. David W. Moser of Rocky Hill, and a daughter, Mrs. Danile M. Rogers of Wenham, Massachusetts, a nurse whose husband is in general practice. There are also nine grandchildren.

William F. Storms, M.D.

### The One and Only Health Magazine

*Today's Health* is the only authoritative magazine of its kind published for the public. Its health education and public relations value should not be underestimated. Last year publication of *Today's Health* showed a deficit of \$150,000. If every member of the American Medical Association would subscribe for one copy monthly for one year this deficit would not occur again.

Copies may be provided for schools, libraries, physician's waiting rooms and influential people in your community. The Woman's Auxiliary is receiving subscriptions, or your order may be sent directly to 535 North Dearborn Street, Chicago 10, Illinois.

## PRELIMINARY PROGRAM

SEVENTH ANNUAL CONNECTICUT CANCER CONFERENCE

FOR PHYSICIANS

WEDNESDAY AFTERNOON, MARCH 10, 1954

1 to 5:45 P. M.

HOTEL TAFT, NEW HAVEN

1:00 REGISTRATION

1:15 WARNING SHADOW — New Film on Lung Cancer

1:30 THE RELATION OF FUNDAMENTAL RESEARCH TO CANCER CHEMOTHERAPY  
Jack Davidson, M.D., *Francis Delafield Hospital, New York City*1:50 PRIMARY CANCER OF THE LYMPH NODES  
George L. Kauer, M.D., *New York Hospital, New York City*2:10 VALUE OF THE PAPANICOLAOU TECHNIQUE IN THE DIAGNOSIS OF CANCER  
N. Chandler Foot, M.D., *Cornell University Medical College, New York City*

2:30 QUESTION AND ANSWER PANEL

3:00 INTERMISSION

3:30 MANAGEMENT OF THE PATIENT WITH ADVANCED CANCER — Panel Discussion  
Memorial Hospital Staff, New York City

Medical Aspects Raymond Houde, M.D.

Surgical Aspects Lemuel Bowden, M.D.

Radiation Aspects James J. Nickson, M.D.

4:30 QUESTION AND ANSWER PANEL

5:00 SOCIAL HOUR

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*Sponsored by*Connecticut Division, American Cancer Society  
Association of Connecticut Tumor ClinicsConnecticut State Medical Society  
Connecticut State Department of Health



## SPECIAL NOTICES

### THE HOSPITAL OF ST. RAPHAEL, NEW HAVEN EDUCATION PROGRAM

February 1954

- | Date  | Subject  |
|---|--|
| Surgical Conference—Monday 8:00-9:00 A. M.                      |  |
| 1   | Case Presentation  |
| 8   | Case Presentation—Thoracic   |
| 15  | Case Presentation  |
| 22  | Mortality and Morbidity  |
| Neurological Conference—Monday 4:00-5:00 P. M.                  |  |
| 8   | Vascular Diseases of the Brain<br>Franklin Robinson, M.D.                |
| Pediatric Conference—Tuesday 11:30-12:30 A. M.                  |  |
| 2   | Case Presentation  |
| 9   | Case Presentation  |
| 16  | Case Presentation  |
| 23  | Case Presentation  |
| Obstetric and Gynecology Conference—Wednesday 11:30-12:30 A. M. |  |
| 3   | Carcinoma of the fundus  |
| 10  | Use and abuse of Pitocin in Obstetrics                                   |
| 17  | Statistics   |
| 24  | Carcinoma of the Vulva and Vagina  |
| Anesthesia Seminar—Wednesday 3:30-5:00 P. M.                    |  |
| 3   | Drug Addiction<br>Norton A. Kazanjian, M.D.                              |
| 10  | Convulsions<br>Ulysses Golia, M.D.                                       |
| 17  | Medico-legal Aspects of Anesthesia<br>Mario Garofalo, M.D.               |
| 24  | Journal Club<br>Leopold Trifari, M.D.                                    |
| Urology Conference—Thursday 11:30-12:30 A.M.                    |  |
| 4   | Prostatic Hypertrophy<br>Elliott Brand, M.D.                             |
| 11  | Prostatic Carcinoma<br>John Goetsch, M.D.                                |
| 18  | Vesical Tumors<br>Lloyd Maurer, M.D.                                     |
| 25  | X-ray Conference and Case Reports<br>Peter Cavallaro, M.D.               |
| Anesthesia Conference—Thursday 2:30-4:00 P. M.                  |  |
| 4   | Volatile Anesthetic Agents—Physical and Chemical Properties—Pharmacology |
| 11  | Anesthetic Gaseous Agents—Physical and Chemical Properties—Pharmacology  |
| 18  | Complications of Inhalation Anesthesia and Their Treatment               |

25 Intravenous Anesthesia—Chemistry and Pharmacology of Barbiturates

Medical Conference—Friday 11:30-12:30 A. M.

- 5 Case Presentation
- 12 Antibiotics  
Paul B. Beeson, M.D.
- 19 Panel—Cardiac As Risk for Surgery in Obstetrics  
Benedict Harris, M.D.  
Leopold Trifari, M.D.  
David Conway, M.D.
- 26 Panel—Carcinoma of the Lung  
Joseph D'Esopo, M.D.  
Max Carter, M.D.  
Robert Shapiro, M.D.
- Pathology Conference—Saturday 11:00-12:00 A. M.
- 6 Clinicopathological Conference
- 13 Surgical and Post Mortem Gross and Microscopic Pathology Demonstration
- 20 Clinicopathological Conference
- 27 Surgical and Post Mortem Gross and Microscopic Pathology Demonstration

### MEDICAL EDUCATION MEETING

February 7-9

Postgraduate medical education needs and how they best can be met by the nation's medical schools will be considered at the 50th annual Congress on Medical Education and Licensure in Chicago's Palmer House, February 7-9.

The meeting will be sponsored by the American Medical Association's Council on Medical Education and Hospitals, in cooperation with the Federation of State Medical Advisory Boards of the United States and the Advisory Board for Medical Specialties.

Three panel discussions will center around a preliminary report of a survey on postgraduate medical education undertaken by the Council on Medical Education and Hospitals. These panels will consider the objectives of such education, how to achieve them, and the needs for such programs.

This being the golden anniversary of the formation of the Council on Medical Education and Hospitals, Dr. Herman G. Weiskotten, chairman of the council, will highlight the AMA's contributions to the training of doctors.

With military needs for medical personnel a problem which may arise unexpectedly, Dr. Frank B. Berry, Washington, assistant secretary of defense (health and medical), will express the views of military authorities on how these requirements best can be met.

The program to be presented by the Advisory Board for Medical Specialties will consider the potentialities of

postgraduate medical training in hospitals not affiliated with medical schools. The current trends in licensure and examination procedures also will be discussed.

The Federation of State Medical Boards will consider the effect of medical licensure on medical education, and the relationship between hospital internship and licensure.

### CONFERENCE ON LEGISLATION

The AMA Committee on Legislation is completing plans for six regional legislative conferences to be held in various sections of the country. These meetings will have a two fold purpose:

1. To explain and perfect the system now being followed for alerting key legislative personnel in the states to situations requiring immediate contact with members of Congress on national legislative affairs.
2. To discuss in detail background information regarding important medical issues pending or coming up in the new Congress.

The meeting for this district which includes Maine, Vermont, Massachusetts, New Hampshire, Rhode Island, Ohio, Pennsylvania, West Virginia, New York, Delaware, Connecticut, Maryland, New Jersey and Virginia will be held in New York Saturday, February 13.

### RURAL HEALTH THROUGH UNITED EFFORTS TO BE NATIONAL CONFERENCE TOPIC

The importance of organized community efforts in the maintenance of healthful conditions in agricultural areas will be the theme of the ninth annual National Conference on Rural Health in Dallas, Texas, March 4-6.

The meeting, sponsored by the American Medical Association's Council on Rural Health, will be held in the Baker Hotel. Physicians, farm and community groups, and agricultural extension workers from all parts of the country will participate.

Dr. Carl S. Mundy, Toledo, acting chairman of the Council on Rural Health, will sound the theme—"Let's Put More 'U' in CommUNITY."

### AMERICAN TRUDEAU SOCIETY ANNOUNCES A POSTGRADUATE COURSE

#### "The Measurement of Pulmonary Function in Health and Disease"

Sponsored by the Medical Schools of Harvard University, Tufts College, and Boston University. Boston, March 22-26, 1954, 9:00 A. M. to 5:00 P. M.

A beginner's course aimed at physicians interested in diseases of the chest who wish to acquaint themselves with the ABC's of methods used in the evaluation of pulmonary function. Methods of analysis of pulmonary function and related cardiac function will be described and demonstrated. Tuition \$50.

Applications and more detailed information may be obtained from Edward J. Welch, M.D., Chairman, Regional

Committee on Postgraduate Courses, 1101 Beacon Street, Brookline 46, Massachusetts.

Connecticut physicians interested in receiving tuition scholarships may apply to their local tuberculosis associations or to the Connecticut Tuberculosis Association, Mabel Baird, Executive Secretary, 43 Farmington Avenue, Hartford.

### AMERICAN ASSOCIATION OF THE HISTORY OF MEDICINE

#### 27th Annual Meeting

New Haven—May 6, 7 and 8, 1954

First formal session on Thursday evening, May 6.

Three sessions devoted to specific topics:

- (1) The Historical Impact of Curative Medicine on Society;
- (2) Interpretations of Chemistry and Medicine;
- (3) The Rise of Statistics in Medicine.

Annual banquet at New Haven Lawn Club, Saturday, May 8.

Headquarters, Hotel Taft.

Dr. John Fulton is president of the Association for the year 1953-1954.

### AMERICAN SOCIETY OF THE STUDY OF STERILITY

#### 1954 Convention

St. Francis Hotel, San Francisco, California. June 18, 19 and 20 (Friday, Saturday and Sunday). Make hotel reservations with Housing Bureau, 300 Civic Auditorium, San Francisco, California.

### SCIENTIFIC PROGRAM FOR DOCTORS ON HAWAIIAN TRIP

The Hawaiian Medical Association has announced a scientific program for physicians who will take part in the American Medical Association's 13 day Hawaiian Holiday Tour which will follow the annual AMA convention in San Francisco next June 21-25.

The party will leave San Francisco aboard Pan American Airways Strato Clippers and United Air Lines Stratocruisers at 11:45 on the night of Friday, June 25—the closing day of the convention—and arrive in Honolulu early the next morning. The party will stay at the Royal Hawaiian Hotel on Waikiki Beach.

The return trip, scheduled at 4 P. M. on July 3, will be made on the luxurious Matson Liner S.S. Lurline, which will dock in Los Angeles on July 8.

All of the reservations are being handled for the AMA by William M. Moloney, general agent, Room 711, 105 West Adams Street, Chicago.

Scientific programs have been arranged for the forenoon of Monday, June 28 and the afternoon of Tuesday, June



29. Following this latter session there will be a social hour, dinner and entertainment with dancing until midnight. The remainder of the time, June 30 to July 3, will be free for visits to the other islands or for enjoyment on the beach.

## VIth INTERNATIONAL CANCER CONGRESS

Organized by the

Union Internationale Contre le Cancer

Sao Paulo, Brazil, July 23-29, 1954

In order to be certain of sufficient travel accommodations to and from the VI International Cancer Congress at Sao Paulo, Brazil, as well as to assure the largest possible attendance of clinicians, investigators, public health officials, etc. and members of their families, arrangements are being considered for both group and individual transportation by air and by steamship to the Congress.

Should general interest warrant it, it will be possible to charter planes from New York and from Miami via regularly scheduled airlines (Pan-American World Airways, Inc., Braniff Airways, Inc., Resort Airlines, Inc., etc.). From preliminary investigations it appears possible to procure round-trip air transportation at a considerable saving. For those taking the chartered flight from Miami to Sao Paulo and return, the rate will be approximately \$480, a saving of \$194 over the regular tourist rate. From New York the rate will be approximately \$560, a saving of \$163 over the regular tourist rate.

These rates are based upon a charter for a DC-4 type of aircraft with a flying time of about 32 hours. There is an excellent possibility that DC-6 or Constellation aircraft (flying time 24 to 26 hours) will be available for our charter, but their availability will depend upon delivery of new planes currently on order by the airlines. In order to break up the long air trip it may be possible to arrange an overnight stop at some half-way point, such as Port-of-Spain, Trinidad, without additional charge.

At this time it is necessary to know the approximate number of people who will want to take advantage of the special rates. It will also be necessary to know whether you intend to extend your stay in South America to visit other countries either before or after the Congress as group tours are being arranged. Advance sample itineraries are available.

For steamship arrangements from New York or New Orleans accommodations have been procured on the Moore-McCormack Line, Grace Line, Delta Line, and the Argentine State Line. Sailings each way are about sixteen days travel time.

If you are interested, kindly let me know at once by writing to: Dr. Brewster S. Miller, American Cancer Society, 47 Beaver Street, New York 4, N. Y.

Please include the following information in your letter:

(1) Whether you prefer to travel by:

(a) Special air charter rate: 1. From Miami. 2. From New York.

(b) Individual air arrangements.

(c) By steamship.

(2) Approximate date of departure and return.

(3) Who will accompany you.

(4) Whether you desire to tour South America: (a) Pre-Congress. (b) Post-Congress and the approximate time you can spend.

Reservations and tour arrangements are being handled by the Ocean Travel Bureau, Inc., 71 West 23rd Street, New York 10, N. Y. You will hear from me or from the Ocean Travel Bureau, Inc. promptly. Passport, visa, and inoculation information will be sent to you.

Hotel arrangements are being handled directly through the Congress office in Sao Paulo. The attached reservation blank should be sent with a \$10 deposit check with your name and address to: Dr. F. Gentil, Secretary-General, VI International Cancer-Congress, Rua Jose Getulio, 211, Caixa Postal 5171, Sao Paulo, Brazil.

As of today the free rate of exchange is \$2.10 for 100 cruzeiros purchased in the United States.

Information concerning the program and travel allotments may be procured from Dr. O. M. Ray, National Committee on the International Union Against Cancer, National Research Council, 2101 Constitution Ave., Washington 25, D. C. Those desiring to present papers in one of the categories under "free presentation of papers" should contact Dr. Ray.

United States representation on the program is being coordinated by the National Committee on the International Union Against Cancer.

## SIXTH WORLD CONGRESS FOR WELFARE OF CRIPPLES

Persons from all parts of the world interested in services for the disabled will assemble at The Hague, Netherlands, from September 13 to 17, 1954, for the Sixth World Congress of the International Society for the Welfare of Cripples.

Representatives of the twenty-six national organizations which are members of the International Society are expected to attend the Congress, as well as representatives of the United Nations, World Health Organization and other governmental and non governmental organizations interested in services for the physically handicapped.

The Congress will be held under the joint auspices of the ISWC and the Netherlands Central Society for the Welfare of Cripples, the affiliated national organization in Holland of the ISWC.

The program will present through plenary sessions, demonstrations, panel discussions and special meetings analyses of developments throughout the world in services for the disabled and means for furthering such services in the medical, social, educational and vocational fields.

OUR NEIGHBORS

New York

The Trudeau-Saranac Institute at Trudeau, New York, is to have a new director of the Saranac Laboratory about May 1. Gerrit William Hendrik Schepers, M.D., D.Sc., of Johannesburg, South Africa who was awarded the Queen's Coronation Medal in recognition of his service in the field of pulmonary disease disability, will relinquish his duties as a faculty member at the Medical School, Johannesburg to come to the Institute.

NEWS

from County Associations

Fairfield

John F. Nolan was installed as president of the Bridgeport Medical Association at the annual banquet of the Association on January 12 in Bridgeport. Other officers installed were Edward P. Kemp, president-elect; Edwin R. Connors, vice-president; Albert Levenson, secretary and Joseph G. Hennessey, treasurer. Members of the Association presented an evening of entertainment.

Joseph C. Quatrano, proctologist at St. Vincent's Hospital in Bridgeport, has been honored by election as a diplomate of the American Board of Proctology.

The late Dr. A. James Boswell has been honored by the Greater Bridgeport Heart Association in the establishment of a \$25 award to each of the senior students in the Schools of Nursing of the two Bridgeport hospitals. The award will be made annually at graduation for the best essay on "Nursing Care of the Cardiac Patient." Bronze plaques will be installed in each hospital with the names of the recipients inscribed thereon.

Alexander J. Tutles, medical director of the Hillside Home and Hospital in Bridgeport, has been appointed to the medical services section of the Connecticut State Department of Health. Dr. Tutles has served Bridgeport for 22 years, as welfare physician for 13 years, then consultant physician at Hillside, and for the past two years as medical director

of this institution for the chronically ill, aged and infirm.

Hartford

At the annual meeting of the Hartford Medical Society held on January 4, Walter Weissenborn was inducted into office as president. The following officers were elected: Louis P. Hastings, president-elect; Stevens J. Martin, secretary; Charles E. Jacobson, assistant secretary; Lewis P. James, treasurer; Arthur C. Unsworth, assistant treasurer; Edward J. Whalen, librarian; Benjamin V. White and William J. Lahey, assistant librarians; Thomas J. Luby, Douglas J. Roberts, and Thacher W. Worthen, trustees; and John F. McDermott, member of the House Committee for three years.

Four members of the Department of Obstetrics and Gynecology of the Hartford Hospital published scientific papers during the past year. Louis F. Middlebrook (with Charles H. Peckham of Manchester) wrote on "Rh Isosensitization, Intrauterine Fetal Death and Hypofibrinogenemia" and Joseph Klein on "Carcinosarcoma of the Endometrium," both in the *American Journal of Obstetrics and Gynecology*. In the *CONNECTICUT STATE MEDICAL JOURNAL* Loftus Walton was the author of "Lymphosarcoma of the Uterus" and Stanley B. Weld of "Leiomyosarcoma of Uterus Following Irradiation for Non Malignant Bleeding."

Charles P. Le Royer, Jr., has joined the medical department of the Travelers Insurance Company as assistant medical director. Dr. Le Royer was an intern at the Hartford Hospital and later a resident in medicine. He comes to Hartford from Beverly, Massachusetts, where he has been engaged in private practice.

George Henry Dalton of New Britain died on November 30, 1953 at the age of 62. He was a past president of the medical staff of New Britain Memorial Hospital, also of the New Britain Medical Society.

Donald B. Wells, one of Hartford's leading surgeons for the past 25 years and an authority on the treatment of burns, died at the Hartford Hospital, December 22, 1953. Dr. Wells was a former president of the Hartford Medical Society and of the Hartford Hospital medical and surgical staff.

The November 1953 issue of the *Hartford Hospital Bulletin* which reached the editor's desk in December is a Memorial Issue to the late Sidney



S. Quarrier, beloved surgeon and recognized leader among the profession in Connecticut. Sidney Quarrier's ability as a teacher early became evident and the popularity of the Saturday morning surgical clinics at the Hartford Hospital testified to his qualifications in this field.

The Board of Directors of HCMA have approved for printing and distributing to the public a four page, two color pamphlet called, "Let Your Doctor Be Your Guide." It will be distributed to each doctor for use in his office and through radio spot announcements some time this spring.

At its December meeting the East Hartford Medical Society elected Raymond T. Houle as president to succeed retiring president, John N. Gallivan. Harvey H. Sirota was named president-elect. Francis Brewer was elected secretary and John J. Murphy becomes treasurer for 1954.

James R. Cullen, past president of HCMA, was the principal speaker at the meeting. He commended the society for its efforts in assisting the East Hartford Hospital to gain official AMA approval.

Bristol Hospital directors elected Herman W. Winters chief of the medical board at their recent December election. Philip S. Brezina was appointed chief of surgery; Harry H. Hershman, chief of medicine; William E. Furniss, chief of obstetrics; Arnold H. Becker, chief of pediatrics; John S. Papa, head of records committee, and Martin I. Hall, secretary of staff.

Walter L. Hogan, Hartford ophthalmologist, now heads the medical and surgical staff of St. Francis Hospital. Richard Buckley is president-elect. Others elected were: John E. Franco, secretary; Timothy L. Curran, treasurer; and James S. Missett, assistant secretary.

Henry L. Birge gave three lectures in December to the Virginia Academy of Medicine and the Richmond Medical Society.

Dr. Wilmar Allen, director of Hartford Hospital for 17 years, retired the first of the year, for reasons of health. His successor is Dr. Thomas S. Hamilton, former director of the Newton Wellesley Hospital in Newton, Massachusetts. Dr. Allen will remain in a consulting capacity.

Ralph A. Richardson has retired as chief of staff at Bristol Hospital after 27 years in this position. Herman W. Winters has been named to succeed him.

## Middlesex

Augustus Harris and Christie E. McLeod of Essex are the authors of "Colloid Adenocarcinoma of the Fundus of the Bladder Arising in the Epithelium of the Urachal Canal" published in *The American Journal of Surgery*, December 1953.

## New Haven

Thomas P. Murdock of Meriden, a member of the AMA Board of Trustees, addressed a meeting of the American Association of Nursing Homes in Minneapolis recently on the subject, "Importance of Standardization of Nursing Homes."

The Yale Medical Society on January 11 presented three papers at the Brady Memorial Laboratory. The first paper was "The Attenuation of Poliomyelitis Virus on Passage Through Tissue Culture," by Joseph L. Melnick and C. Allan Phillips. The second paper was the "Fine Structure of Neurons" by Sanford L. Palay, and the third paper was "The Orbital Undercutting in the Treatment of Various Benign Psychiatric Disorders with Especial Reference to Psychoneuroses, Depressions and Senile Disturbances," by William B. Scoville. The last paper was "The Fe59 Turnover Rate of Cytochrome C," by S. C. Finch and J. F. Ross.

The New Haven Medical Association meetings were held as usual and the paper on January 6 was a very interesting discussion of "The Soft Tissues in X-rays, as Pertaining to Pediatric Radiology." The paper was given by Edward Neuhauser, director of The Department of Radiology, Children's Hospital, Boston. On January 20 Edwin Astwood, Department of Metabolism, New England Center, Boston, spoke on "The Advantages of Metabolism of The Pituitary Gland and Related Factors." On February 3 C. Stuart Welch will be the speaker of the evening.

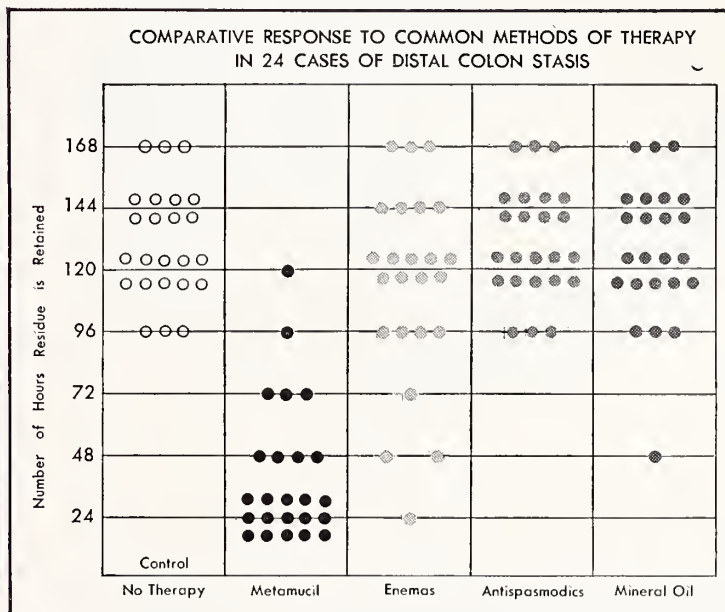
The Society of The University Surgeons will hold its meeting in Rochester, New York on February 11, 12, 13.

## New London

The regular meeting of New London County Medical Association was held Thursday, January 7, 1954, at 8:30 P. M., at the Uncas-on-Thames Sanatorium. The speaker was John Leonard, medical



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\*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. *Rev. Gastroenterol.* 19:154 (Feb.) 1952.



director of Hartford Hospital, his subject, "Hypertension."

Hugh Lena was recently appointed to the active surgical staff of the Lawrence and Memorial Associated Hospitals.

L. Frank Cole has been appointed anesthesiologist at the Lawrence and Memorial Hospital.

On January 5, Norman L. Cressey, director of medical education at Uncas-on-Thames, addressed the staff of the Lawrence and Memorial Hospital on "Virus Pneumonia."

## Polio Foundation Aids Nursing Recruitment

From the March of Dimes this year will go \$47,690 to assist the Committee on Careers of the National League for Nursing to continue its national program of recruitment of students for schools of professional and practical nursing. This committee is sponsored by national nursing, medical and hospital organizations along with other professional and business groups. The National Foundation for Infantile Paralysis is making this grant as it considers adequate nursing an important element in the treatment of polio patients.

## NEW BOOKS IN REVIEW

*HUNTED HERETIC: THE LIFE AND DEATH OF SERVETUS.* By Roland H. Bainton. Boston: Beacon Press. 1953. 270 pp. \$3.75.

Reviewed by STANLEY B. WELD

Two points of interest should attract the Connecticut physician to this book: (1) the author is Titus Street Professor of Ecclesiastical History at Yale; (2) the subject of the story in addition to his other varied accomplishments was a Doctor of Medicine of the University of Paris. Connecticut students of religious history need no introduction to Professor Bainton but to the medical profession his is probably an unfamiliar name. Toward the production of this historical document Professor Bainton began to lay the groundwork in 1926. The instance for the actual publication was the anniversary of the execution of Servetus on October 27, 1553.

To the commemoration of this event the Yale Historical Library collected and placed on exhibit its valuable collection of the writings of Servetus, a very rare display. Together with these were exhibited various commentaries and biographies, including Professor Bainton's "Hunted Heretic."

Now for the man, Michael Servetus. His primary interest for physicians lies in the fact that buried in the fifth part

of his volume on the Restitution of Christianity, there is an excellent description of the lesser circulation of the blood. Servetus' discovery marked a noteworthy advance in the knowledge of human anatomy and physiology of the blood. He retained the view of Galen that the blood originated in the liver and because of this fact missed the larger understanding of the circulation of the blood throughout the body. He did discover, however, the exact course of the blood through the heart and lungs.

The remainder of the book is largely filled with Servetus' theological views, his violent opposition to infant baptism, his trials and escapes, his continuing controversy with John Calvin the great dissenter, and his final trial at Geneva and his death at the stake at Champel. His was a stormy existence; the end is reminiscent of that death on Calvary. Servetus is quoted as crying out while the flames were mounting around his fettered body, "O Jesus, Son of the Eternal God, have pity on me!"

One is forced to close Professor Bainton's vivid account of this 16th century zealot with a realization that men really died for their convictions in the Middle Ages. Born in Spain, educated in France and Switzerland, author, editor, lecturer, and practitioner of medicine, he was almost constantly in hot water because of his views on the Trinity and on infant baptism. "Throughout the unruffled decade, by the bedsides of the sick, he was engaged in eschatological reveries; while editing Thomas Aquinas in Spanish he was seething with revulsion against the usurper of the keys of the Kingdom." He was finally to fall a victim of the persevering antagonism of our spiritual ancestor, John Calvin, "the granite block from which we of the Puritan tradition have been carved." As the author points out: "This study may be revealing as to the reasons why men persecute and the reasons why, as Christians, they should not."

*FEMALE SEXUALITY.* By Marie Bonaparte. New York: International University Press, Inc. 1953. 225 pp. \$4.50.

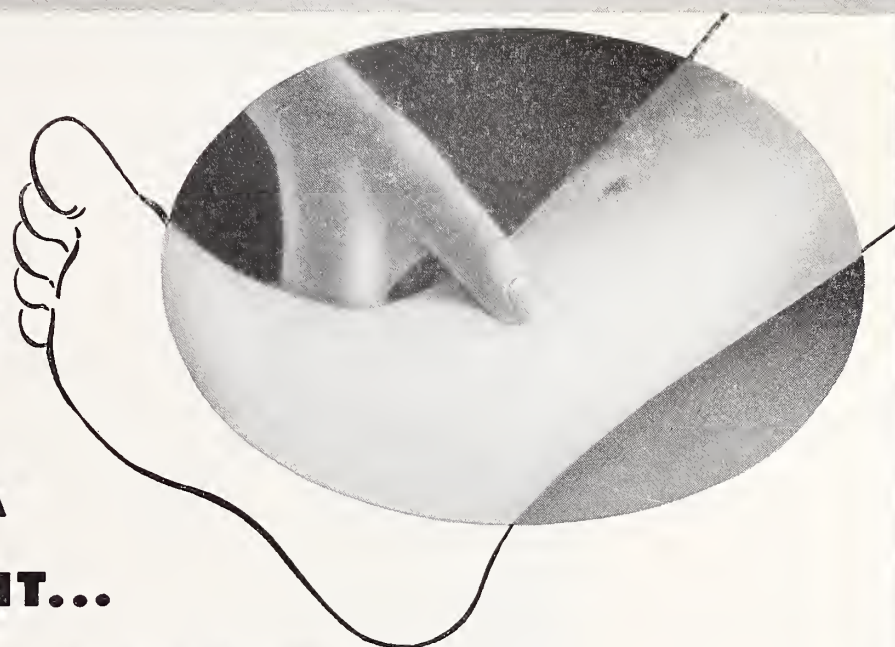
Reviewed by RICHARD KARPE

Theodor Reik, a prolific writer himself, in one of his many self-analytic writings calls Marie Bonaparte an amazing person. One certainly has to agree with him if one reads this amazingly readable book. The reader of this JOURNAL may not know that Marie Bonaparte is a member of one of the few remaining royal families in Europe, that she became a practicing psychoanalyst in Paris, and that her friendship with Sigmund Freud played a decisive part in the rescue of Freud and his family from the Nazis. Besides that she is a fruitful contributor to psychoanalytic literature.

This book grew out of thinking and writing of many years duration. Papers which I heard at the International Psychoanalytic Congresses in Lucerne and Marienbad in 1934 and 1936 form a part of this book. She reviews and discusses the whole psychoanalytic literature on the topic of female sexuality and explains her own views which differ in some significant details from those expressed in present writings of other authors. She stands firmly on the basis of the psychoanalytic theory by Freud but comes sometimes to differ in results. Her main topic is the disturbances of the female libido. She starts with woman's frequent mal-

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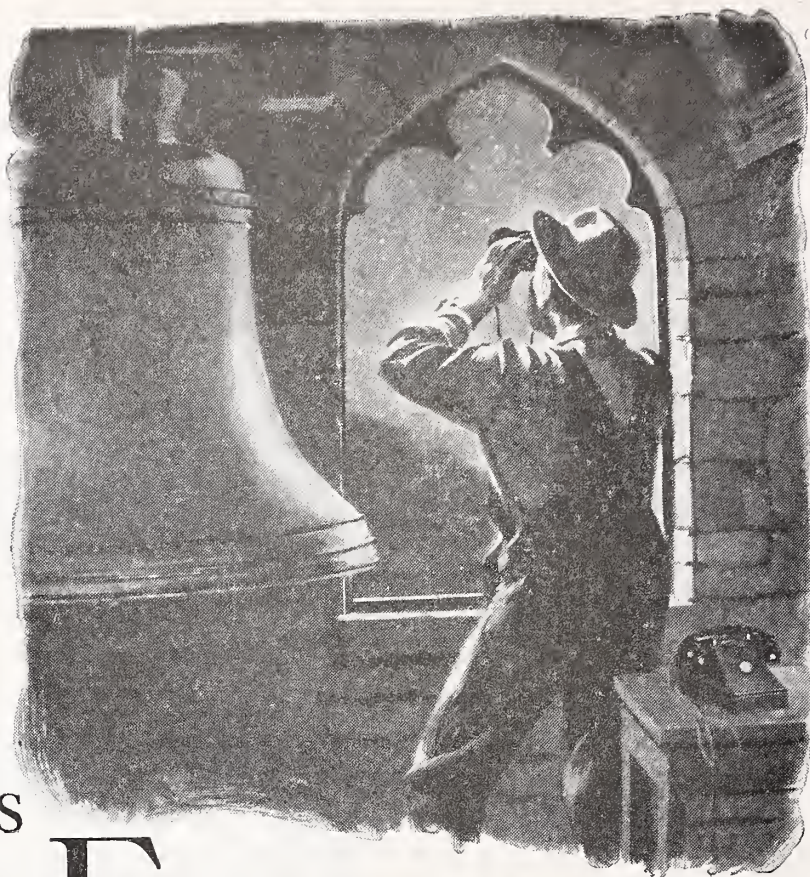
1. Abromson, Julius, Bresnick, Elliott, and Sapienza, P. L.:  
New England Jour. Med.,  
243:44, July 13, 1950.

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adaption to the erotic function which she separates clearly from woman's reproductive function. She uses a reaction of the girl towards a difference between the sexes for a differentiation of personality types, calling them the renouncers, the claimers, and the acceptives, joining the many mostly unsuccessful attempts of other authors to find simple classifications of personality types.

Among the modifications of presently accepted views she suggests a change of the now famous table of Karl Abraham about the development of the libido. She subdivides with apparent good reason the phallic stage into an early and late one, a subdivision similar to the one which was proposed by Abraham for the preceding oral and anal stages but which he omitted for the phallic one. Marie Bonaparte suggests a logical correction of that omission. She uses biological, anthropological, and psychological concepts to explain her views and discusses in a very convincing way why the woman has greater difficulties with her adaptation to the erotic function than the man. For the man the erotic and reproductive functions are concentrated in one identical act, the coitus which is connected with pleasure. The woman has in her preparation for that act and in the consequences of it to suffer many discomforts: menstruation, defloration, pregnancy, parturition, and lactation. A general biological defense against any intrusion in one's body together with additional cultural inhibitions increase the woman's anxieties towards sex. Those anxieties are associated with a constitutionally smaller quantity of libido and make the complete undisturbed adaptation of the woman to her erotic function rather an exception than a rule; but many women are still capable of erotic pleasures, craving for caresses with absence of masochism. Woman's share in sexual pleasure is deducted from remainders of virility in female organism and dependent on man's potency and upon the time which man allows for her slower gratification. The earlier in her development the girl observes the sexual act, the more it is conceived by her as an aggression which interferes with an ideal erotic development. She has to learn to differentiate between masochism and passivity, to accept completely her normal passive erotic function in intercourse. She has to see that normal vaginal coitus does not hurt a woman, but quite the contrary. If passivity is confused with masochism, the girl might get frightened and reject her passive role.

Any one familiar with the psychoanalytic literature will read this book with great gain. It certainly will become required reading for any student of psychoanalysis. The medical practitioner with only partial knowledge of the psychoanalytic discussions of this topic will be able to follow and understand a great part of this book which is not burdened with extensive clinical examples or case histories. The advertisements which try to sell this book with the promise that it explains the facts that Kinsey reports are untrue. One hears and reads more about Kinsey but that one learns more about female sexuality from Marie Bonaparte.

(Truly an amazing book. All gynecologists should read it and the GP should take it with him for travel reading.—*Editor.*)

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**DISEASES OF WOMEN.** (Tenth Edition.) By Robert James Crossen, A.B., M.D., F.A.C.S. Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine; Section Head of Unit in Obstetrics and Gynecology, St. Louis City Hospital; Assistant Gynecologist and Obstetrician to Barnes Hospital and St. Louis Maternity Hospital; Assistant Gynecologist to St. Louis Children's Hospital; Gynecologist and Obstetrician to St. Luke's Hospital; Member of American Academy of Obstetrics and Gynecology, Central Association of Obstetricians and Gynecologists, American Radium Society, American Society for the Study of Sterility, International Fertility Association; Diplomate of the American Board of Obstetrics and Gynecology. *St. Louis: C. V. Mosby Co. 1953. 935 pp. \$18.50.*

Reviewed by STANLEY B. WELD

Since the last previous edition of Crossen's "Diseases of Women" appeared in 1941 the senior author, Harry Surgeon Crossen, has passed on to his reward. The monumental task of producing the present edition was assumed and consummated by the present author single handed, if we exclude two sections by Drs. Willard Allen and A. N. Arneson and editorial advice and assistance from several others. To say that the task has been well done is expressing it mildly. One need only read Chapter 1 to realize some of the changes in the text book which time and progress have made necessary. For example, advances in the knowledge of embryology and a new concept of oogenesis and the development of various ovarian structures have helped to produce a clarification of ideas on the origin of tumors composed of specific ovarian mesenchyma as well as those produced from tissue accidentally enclosed in the ovarian parenchyma during the developmental stage of the ovary. Dr. Willard Allen has contributed in Chapter 1 a discussion of "Endocrine Relations Concerned in the Ovarian Cycle."

In Chapter 2 the author has added an entire new section on "Psychosomatic Aspects of Gynecology;" a short section on examination of the breasts; new special examinations such as premarital, culdoscopy, peritoneoscopy, vaginal smears, and cervical biopsy; and several newer pregnancy tests. The former detailed description of the preparation of a patient for examination has been omitted.

In Chapter 3 we find radical node dissection discussed and in Chapter 6 new material on conization, added discussion of puerperal endometritis, and the newer treatment



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of tuberculosis of the uterus outlined. New material in Chapter 7 covers the etiology of uterine myoma, miscellaneous growths of the uterus and benign tumors of the cervix.

In Chapter 8 there is new material on the etiology of cancer and of cancer of the cervix in particular. Intra-epithelial carcinoma of the cervix is a new section and there is new material on early diagnosis of cancer of the cervix. In this chapter under the treatment of carcinoma of the cervix there is a section on "Radiation Therapy" by A. N. Arneson, M.D., and a discussion of the operative treatment by the author. New material on the etiology of adenocarcinoma of the corpus is offered and the treatment of sarcoma of the uterus is amplified.

In the remaining eight chapters there is much that is new. Some of these follow: operative results in chronic pelvic cellulitis, treatment of tubal tuberculosis, miscellaneous rare diseases, histogenic classification of ovarian tumors, congenital anomalies, Stein-Leventhal syndrome, malformations of the genito-urinary tract, endocrine dysfunction, painful menstruation, and an entire new chapter on "Sterility and Sexual Disturbances."

Two chapters have been deleted, one on "The Lower Intestinal Tract in Relation to Gynecology" and the other on "Invasion of the Peritoneal Cavity." Many new illustrations appear in this edition as well as several excellent new colored plates. The lists of references have been returned to the end of their respective chapters where they rightfully belong and of course have been brought up-to-date. There has been a shift in bold face type and light face capitals which may or may not be confusing but at least expresses an apparent desire on the part of the author for a change.

It is an excellent edition and will be welcomed as a valuable reference. The author is to be complimented on the text and the publishers on the finished product with its new red and blue cover.

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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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No. 3

## ARTERIAL LIGATIONS IN CIRRHOSIS OF LIVER

### Selection of Patients and Results

JACOB K. BERMAN, M.D., E. DALE HABEGGER, M.D., and DON C. FIELDS, M.D.,  
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**A**TROPHIC cirrhosis is a progressive degenerative disease and therefore any new ideas which may lead to an alteration of its course or aid in the management of its lethal complications should be welcome. The normal liver is an elastic vascular organ without definite control over the amount of blood it receives or discharges, yet because of its distensibility it is able to adjust to wide variations in blood volume. The atrophic cirrhotic liver is a shrunken, fibrotic, inelastic organ which cannot adjust to changes in blood flow nor permit a sufficient amount of portal blood to reach its ischemic parenchyma. Under these conditions the liver and the entire splanchnic bed may harbor huge networks of abnormal arteriovenous and venovenous communications which bypass the sinusoids.<sup>8,1e,1h</sup> These auxiliary passages or shunts may become inordinate leading to vascular and lymphatic decompensation with resultant esophageal and other varices and ascites.

Ligations of the arterial components of this network should reduce the high pressure in the portal system, decrease the competition between venous and arterial constituents for peripheral resistance permitting a greater volume of portal blood to flow through the liver. The spontaneous Eck fistulae could then function on a much lower pressure level.<sup>1a,1b,1d</sup>

#### DANGERS OF THE PROCEDURE

Occlusion of the arterial or venous hepatic inflow is not without danger unless in either instance compensatory vascular adjustments have developed. This is especially true of the portal venous supply

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#### SUMMARY

This article is a report of the results of hepatic, splenic and left gastric arterial ligations in patients with advanced atrophic cirrhosis of the liver with portal hypertension one or more years following surgery.

The rationale for the procedure, its major hazards, indications and contraindications are considered.

A clinical classification of patients with portal cirrhosis is suggested so that candidates for surgery may be better categorized. Diagnostic measures which may aid in the proper selection of patients for surgery are reviewed.

---

but it is also important in arterial interruption. Experimental and clinical observations emphasize the following perils.

(1) Necrosis. The chief danger from interruption of the arterial blood supply to the ischemic liver is anoxemia with patchy necrosis. This hazard has been greatly reduced by the use of antibiotics which decrease the indigenous bacterial flora. However, hepatic infarction may occur and the prediction of

*Presented at 28th Connecticut Clinical Congress, New Haven, September 16, 1953*

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this complication is one of the major challenges in the selection of patients.

(2) Portal venous thrombosis may arise as a result of arteriovenous shunts from hepatic artery to portal vein producing eddies of blood in the capacious portal bed inviting clot formation. If the portal vein is thrombosed and if the hepatic artery is ligated the liver might be deprived of its blood supply except for collaterals which enter into its angiomatous transformation.<sup>1e</sup>

(3) Decrease in blood flow through the liver. Animal and perfusion experiments show that ligation of the hepatic artery in atrophic cirrhosis permits a greater flow of blood from portal through hepatic veins. Total blood flow is not significantly altered.<sup>2</sup> If numerous arterial-portal venous shunts are present and if a portacaval anastomosis is created, blood would flow from the arterial to the portal venous bed and into the vena cava completely bypassing the liver.

(4) Difficulty of the procedure. The operation is not easy and requires good team work, careful dissection and complete hemostasis. No less important is the pre- and postoperative care.

(5) Variations in arterial supply. Many abnormalities exist in the origin and distribution of the hepatic, splenic and left gastric arteries.

A single celiac common hepatic artery is found in about 60 per cent of normal persons; 40 per cent will have two or more hepatic arteries with various sites of origin. Practically all aberrant vessels enter the porta hepatis and supply lobes or segments of the liver. Collaterals from the phrenics and other arteries communicate with intrahepatic terminals rather than the main trunks of the common hepatic or its principal branches. The general distribution of the hepatic artery is lobar or segmental with intrahepatic communications in only 25 per cent of normal livers.<sup>6</sup> This does not include the rich subcapsular plexus concerning which little is known at present. The vagaries of the hepatic artery have been described by one of us previously.<sup>1d</sup> We believe that in over 90 per cent of cirrhotics with adventitious arteriovenous communications we can locate the common hepatic and its additive or substitutionary vessels and thereby reduce the arterial pressure within the liver, permitting more portal venous blood to flow through the sinusoids.

(6) Sudden deprivation of arterial blood supply does not permit adjustment. This is certainly true

in the common carotid artery. Yet in the presence of hemangiomas of the brain its ligation rarely produces necrosis but often gives relief. Perhaps a slow method of obliteration of the hepatic artery distal to the gastroduodenal with reacting polythene film or other fibroblastic material may be advantageous.

#### INDICATIONS FOR THE PROCEDURE

Thus far we have used the operation only in advanced cases of atrophic cirrhosis with recurrent bleeding and persistent ascites; complications which are known to be lethal within a relatively short time. These patients failed to improve or were actually deteriorating under prolonged medical management.

Splenectomy and hepatic arterial ligation was done in one child with portal hypertension, hypersplenism, and complicated by ascites and bleeding from the gastrointestinal tract.

#### CLINICAL CLASSIFICATION

Patients with advanced atrophic cirrhosis may be classified into five major groups, based upon clinical and laboratory studies.

Group I. Atrophic cirrhosis with transient ascites. The portal system is in temporary vascular decompensation and the ascites is probably due to electrolyte imbalance, lymph and portal venous stasis, hypoproteinemia and hypoprothrombinemia.<sup>1f</sup> Ascites is usually controlled by a low sodium diet, cation-anion resins, mercurial diuretics, iron, vitamins, abstinence from alcohol and paracentesis of small amounts of fluid as needed. Surgery is not indicated.

Group II. Atrophic cirrhosis with persistent ascites. There is hepatic venous and lymphatic decompensation, protein and electrolyte imbalance which cannot be controlled by medical management or paracentesis. Surgery may be indicated.

Group III. Atrophic cirrhosis with bleeding esophageal varices indicating hepatic venous decompensation. Surgery is indicated.

Group IV. Atrophic cirrhosis with uncontrolled ascites and bleeding varices indicating complete vascular and lymphatic decompensation. Surgery is indicated.

Group V. Cirrhosis with persistent ascites and bleeding varices plus one of the following contraindications to surgery: a. active bleeding varices; b.

continuing jaundice; c. systemic hypertension; d. large liver; e. other contraindications common to all types of surgery such as: cardiac decompensation; acute pulmonary infection; bacteriemias, etc. The Sengstaken-Blakemore tube or transesophageal ligations<sup>3</sup> may be indicated as emergency measures to control bleeding; later arterial or venous operations may be performed more safely.

The reasons for the contraindications listed in Group V should be briefly explained. a. Active hemorrhage. Exanguinated patients are in hemato-genic shock and, despite a continuous flow of blood, hypotension may persist and so impair the function of the ischemic liver as to make shock irreversible. Moreover, after the blood volume has been replaced repeatedly clotting factors may be disrupted due to the incompatibilities or other disturbances which are not yet clearly understood. Immediately after hemorrhage there is a decrease in clotting time and resistance to heparin. With the control of bleeding the blood becomes hypocoagulable and sensitive to heparin. Should bleeding continue clotting time may be greatly prolonged. In fact, after anticlotting factors have become predominant for awhile they are difficult to control, even with the use of protamine, plasma or whole blood.<sup>4</sup> Two of our first twelve patients were operated upon during active bleeding and subsequently died.<sup>1d</sup> One had ligations of the hepatic and splenic arteries and the other had in addition transesophageal ligations. In both cases portal pressures were definitely lowered following arterial ligations. In our original cases we tied the hepatic and splenic arteries but not the left gastric. It may be, as Witter and First<sup>10</sup> have pointed out, that by so doing we increased the pressure in this component of the celiac axis and actually favored more bleeding.

(b) Continuing jaundice. Many articles and personal case reports indicate good results from the operation in the presence of jaundice. However, to us it implies either advanced hepatocellular damage, or occlusion of bile ducts due to edema, inflammation or degeneration of ductal epithelium. Transient jaundice is common and no doubt represents temporary duct occlusion. However, the role of hepatitis as a causative or complicating factor in many types of cirrhosis is not clearly understood. It is noteworthy that in obstructive biliary cirrhosis, relief of the obstruction is of great value.

(c) Systemic hypertension is rare in patients with advanced Laennec's cirrhosis.<sup>1g</sup> Normally there is a

ratio of pressures between the hepatic arterial (about 120 mm. of mercury) and portal venous (about 10 mm. of mercury) components of approximately 10 to 1. In most cirrhotics the portal pressure is elevated but the arterial pressure remains the same. Therefore, the ratio becomes greatly reduced amounting to about 5 to 1. Livers with such moieties of circulation seem to withstand the sudden decrease of arterial pressure after ligation, although there is a temporary insufficiency of arterial blood as manifested clinically by what we have termed "hepatic crisis." In patients with hypertension the ratio of pressures is again about 10 to 1, just as in the normal where arterial ligation is hazardous. It is however on a much higher level. One of our patients had a portal pressure of 22 mm. of mercury and the systolic blood pressure 230. The cirrhotic liver cells under such conditions obtain their oxygen through excessive arterial and venous pressure which they demand to remain viable, and they cannot stand the sudden drop to near zero after hepatic arterial ligation. In this regard the sequence may be compared to the anuria which follows prolonged hypotension in patients with ischemic kidney and high blood pressure. Indeed, the anuria in the hepatorenal syndrome following hepatic-splenic-arterial ligation may be due to the fall in blood pressure which usually occurs in hepatic crisis. Liver cells seem to remain viable long enough for collaterals to form, if they have become acclimated to the ratio of pressures which usually occur in cirrhotics who are normotensive.

(d) The large cirrhotic liver is a contraindication to hepatic arterial ligation, because a sudden decrease in its size is a grave omen and hepatic arterial ligation might induce this change. Moreover, we believe that it indicates an acute phase of the disease which should be allowed to regress. Perhaps a more significant finding is the difference in vascular moieties in the small atrophic cirrhotic liver where the portal venous component comprises about 75 per cent or more of the total blood flow, and in the enlarged cirrhotic liver where the hepatic artery contributes approximately 75 per cent and the portal vein, 25 per cent.<sup>7a</sup>

(e) Cardiac inadequacy due to congestive failure or constrictive pericarditis and the accompanying passive hyperemic cirrhosis will not respond to any form of liver therapy until compensation is restored. Acute pulmonary infections, bacteriemias and other complications must be recognized and treated. We



mention these because in one of our failures there was "cardiac" cirrhosis and in another there was an unrecognized subacute bacterial endocarditis superimposed on mitral stenosis which caused the demise of the patient and which we did not discover despite a long period of observation until an autopsy had been done.

#### AIDS IN SELECTION OF PATIENTS

A reliable test for ascertaining the presence of arteriovenous shunt mechanisms would be helpful. Several methods seem promising. Clinical and laboratory studies will enable us to classify the patient in one of the five groups listed. Measurements of the hepatic venous pressure reveal commensurate changes in sinusoidal and portal pressure and are therefore guide posts in the selection of patients who are suitable for ligation. The normal gradient is from 8 to 10 mm. of mercury in the portal vein to 1 to 2 mm. of mercury in the hepatic vein. In early cirrhosis, portal venous pressure is high and hepatic venous pressure is lower than normal. This implies obstruction without provision for collateral circulation and here ligation would not be indicated. Friedman and Weiner<sup>5</sup> placed a catheter within the hepatic vein as far as it could be conveniently inserted and another in the portal vein into the liver so that the two catheters came to lie on either end of the sinusoids. They found that the average free portal venous pressure was 13 and the average occluded pressure 9.3 cm. of water, whereas the average free hepatic pressure was 0.4 cm. and the average occluded hepatic pressure was 14.3 cm. of water. The average sinusoidal pressure as estimated at a midpoint between the occlusive portal and the occlusive hepatic pressure was 11.5. The average free sinusoidal pressure by the same method of calculation would be 6.7 cm. of water. If the hepatic venous pressure is higher than the highest normal portal venous pressure, cirrhosis with shunt mechanism is probably present. Thus Meyers and Taylor<sup>7b</sup> showed that in eighteen patients with Laennec's cirrhosis the mean hepatic sinusoidal pressure was 21 mm. of mercury as opposed to a mean pressure of 5 mm. of mercury in a controlled group without hepatic disease. Moreover, no patient with cirrhosis had a pressure as low as the highest controlled value, establishing for the procedure a high degree of accuracy in distinguishing cirrhosis. Most important was the demonstration by these authors that there was a close and positive correlation between the height of the sinusoidal pressure and an increase in

blood volume, presence of esophageal varices and complication of cirrhosis by jaundice. In contrast, no correlation existed between the degree of increase in sinusoidal pressure and the presence or absence of ascites. This observation indicates that the two complications may be caused by different mechanisms.

The arteriovenous oxygen difference may be determined in the normal and cirrhotic patient through venous catheterization before surgery and evaluated after surgery by cannulation.<sup>9</sup> If the arteriohepatic venous difference is greater than normal one would be led to assume that perhaps cirrhosis is present and that the increase in the difference is due to increased oxygen uptake by the ischemic liver cells, sluggishness of flow through the liver and splanchnic bed permitting a more complete deoxygenation and diffusion of oxygenated blood through shunts into the systemic circulation. If the patient has superficial abdominal venous collaterals, the arterial-portal venous oxygen difference may be determined and compared with hepatic venous and systemic venous oxygen content. Our studies show that there is a great decrease in the arteriportal venous oxygen difference over that of the arterio-systemic venous difference indicating that many arteriovenous shunts exist in the portal bed.<sup>1b</sup>

Complete arterialization of the hepatic blood supply in dogs by aortic-portal venous anastomosis produces dilatation and thickening of the portal vein radicles with acute necrotizing vasculitis.<sup>11</sup> A careful study of portal venous branches in atrophic cirrhosis using special stains may disclose similar changes in man. The routine use of needle biopsy affords the pathologist an opportunity to compare morphological variations with oxygen content and pressure changes in the portal vein.

These tests are not pathognomonic and must be interpreted in the light of clinical studies in the selection of cases suitable for ligation.

#### CLINICAL EVALUATION OF ARTERIAL LIGATION

A large number of carefully observed patients over a period of years is required in order to draw conclusions. Moreover, studies must be limited to one type of cirrhosis and classified into the various groups within this type. Even then, the natural course of the disease is known to vary greatly and individual cases must be carefully and objectively evaluated. We have received numerous reports from our colleagues and have read the many published

observations for and against arterial ligations but we feel that even with lengthy questionnaires, conclusions drawn from experiences other than our own might be misleading. Therefore, we have elected to report the results in all patients who have been followed for one year or more.

HEPATIC, SPLENIC AND LEFT GASTRIC ARTERIAL LIGATIONS IN  
ADVANCED PORTAL CIRRHOSIS

	NO. CASES	PER CENT
Number of cases operated upon.....	23	
Immediate deaths (during first three weeks after surgery) .....	7	30.4
Active bleeding from esophageal varices....	3	
Systemic hypertension .....	2	
Patchy necrosis of liver and spleen with hemorrhage in liver capsule, pericardium, in one patient, autopsy not obtained in the other		
Mitral stenosis with active streptococcus viridans, subacute bacterial endocarditis plus portal cirrhosis.....	1	
Post operative hemorrhage.....	1	
Deaths within one year.....	9	39.1
Recurrent bleeding from esophageal varices	3	
Recurrent ascites with gradual hepatic insufficiency .....	5	
Coronary occlusion .....	1	
Alive without ascites or bleeding.....	6	26.1
Alive with recurrence of bleeding.....	1	4.3

Mr. E. H., our first patient, was operated upon in November 1950.<sup>1c</sup> His liver profile is now normal and there has been no recurrence of ascites or bleeding since surgery. One year after operation we repaired a large umbilical hernia and secured a liver biopsy which showed much hepatic regeneration. Another patient, Mrs. R. S., returned to the hospital for herniorrhaphy one year after surgery. About 200 cc. of ascitic fluid were present. We were impressed by the increase in size of the liver and change in its consistency. She has not required paracentesis and there has been no bleeding.

The only patient with bleeding was Mrs. K. J. who had a triple ligation on July 12, 1951. At this time the hepatic, splenic and left gastric arteries were doubly ligated and divided and splenectomy was performed because of hypersplenism. Portal pressure at that time was 320 mm. of H<sub>2</sub>O and after ligation it fell to 230 mm. H<sub>2</sub>O. Her postoperative course was satisfactory and she remained free of ascites and bleeding although she was placed on a low sodium diet and given cation-anion resins occasionally. Early

in 1953 she returned to her alcoholic diet and did not report to the Outpatient Clinic. In July 1953 she re-entered the Indianapolis General Hospital because of bleeding from esophageal varices. Hemorrhage was controlled with a Sengstaken-Blakemore tube and two weeks later she was re-explored. There was no ascites and the liver had increased in size. Portal pressure was 120 mm. of H<sub>2</sub>O. The esophagus and cardiac end of the stomach were opened and no discernible varices were found. There were, however, three mucosal longitudinal ridges which represented thickened perivenous fibrosis. These were imbricated with chromic catgut sutures. We believe that hemorrhage was due to esophageal erosions. Biopsy of the liver showed some changes with no apparent progression of the disease (Figures 1 and 2).

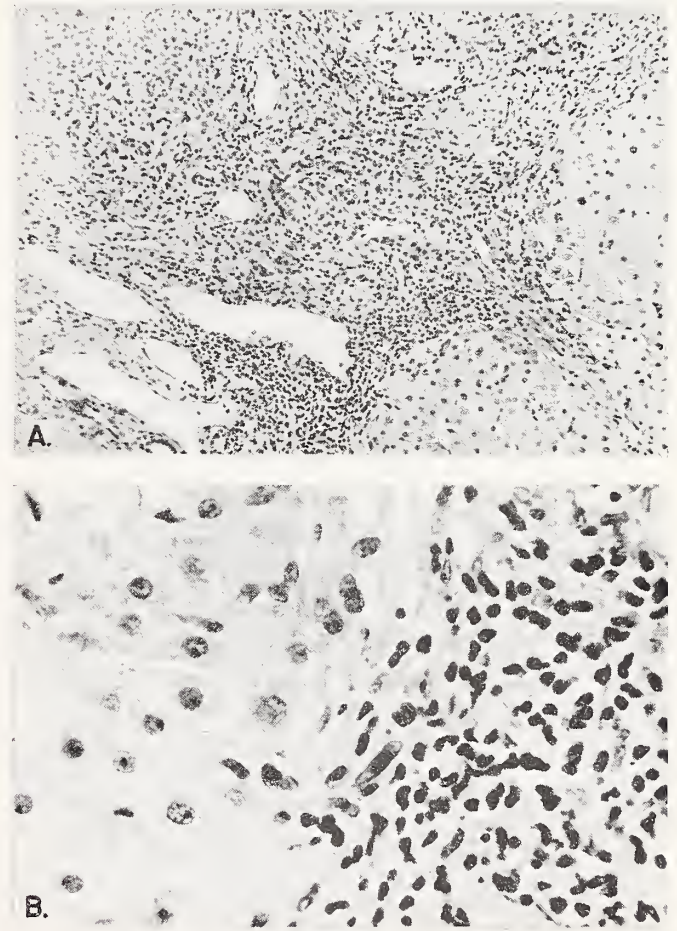


FIGURE 1

Mrs. K. J. Biopsy of the liver taken prior to ligation of the hepatic, splenic and left gastric arteries in July, 1951

- A—Low power photomicrograph × 180 showing relatively small amounts of normal liver parenchyma with wide areas of fibrosis densely infiltrated with lymphocytes
- B—High power photomicrograph × 850 showing profusion of lymphocytes in the connective tissue



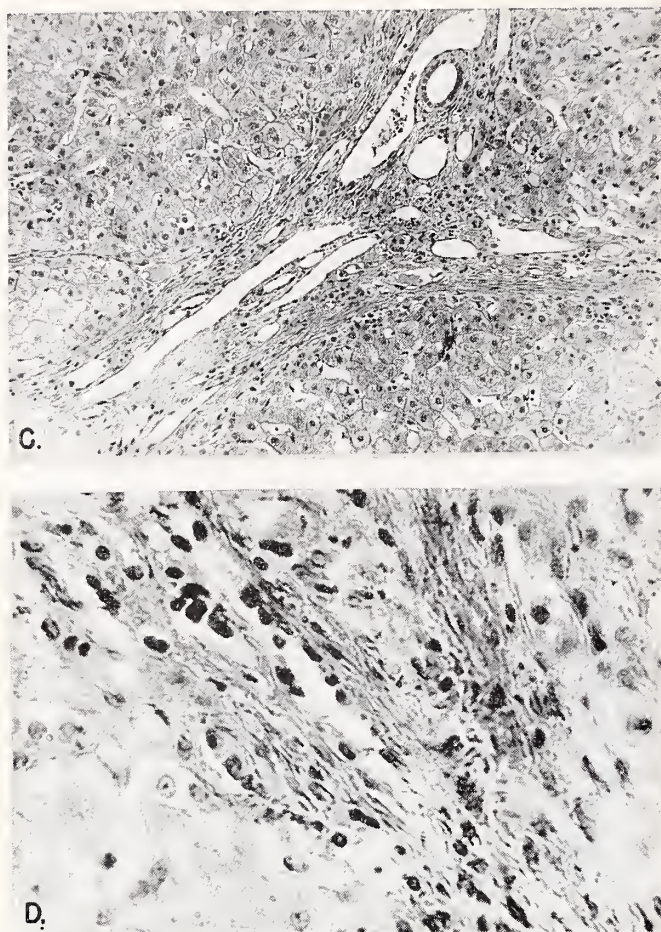


FIGURE 2

Mrs. K. J. Biopsy of liver taken two years after ligation of the hepatic, splenic and left gastric arteries  
C—Low power photomicrograph  $\times 180$ . There is a decrease in interlobular connective tissue as compared with "A" in Figure 1

D—High power photomicrograph  $\times 850$  showing the sparsity of lymphocytes as compared with "B" in Figure 1

All survivors now have satisfactory liver profiles. This would give us an overall salvage in advanced portal cirrhosis of 30.4 per cent including all the contraindications which we now know to exist. It should be noted that all of these patients are now on more or less restricted sodium diets and they are observed at frequent intervals.

Ligations of the hepatic, splenic and left gastric arteries when combined with dietary management, the use of cation-anion resins during the early and sometimes later postoperative periods, restriction of sodium to about  $1\frac{1}{2}$  Gm. per day seem to give the best results in our patients.

#### DISCUSSION

Arterial ligations in portal cirrhosis are still in the

experimental stage and their use at present should be restricted to cases of atrophic cirrhosis which are unsuited for other types of therapy so that results may be properly evaluated. Our failures have been due, in part, to an acceptance of all late cirrhotics without definite criteria for the use of the procedure. Perhaps better results will be obtained when more accurate methods for selection of patients are available and when more is known of the effects of slow progressive occlusion or by combinations of occlusion and shunts.

The best way to evaluate the results is the clinical method, because the height of portal pressure in itself neither implies nor presages the bleeding of varices or the control of that bleeding. In fact, bleeding varices occur without portal hypertension and fail to appear in the presence of extremely high portal pressures. The same is true of ascites. Improvement in liver function as determined by tests is evidence of parenchymal regeneration and gives added assurance of arrestment of the hepato-cellular degeneration. But the correlation between laboratory studies and clinical wellbeing is not always commensurable. Therefore, the absence of bleeding, ascites, jaundice, edema, vomiting or diarrhea, anorexia, somnolence or lethargy and a return to work indicate a good result.

When the cause of atrophic cirrhosis is known, the need for palliative maneuvers will be over. Until then it behooves us to seek methods which will, at least, delimit the progressive changes and decompensations which occur so that lives may be prolonged. The ultimate goal is the restoration of normal hepatic physiology.

This study was supported by a grant from the Charles J. Wolf Foundation for Medical Research.

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## DEPRESSION AND ITS CLINICAL MANIFESTATIONS

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### SUMMARY

This paper is a presentation of the descriptive psychopathology most frequently encountered in depression, together with some remarks on the difficulties in the classification of depressive states.

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more divisions formulated in the nineteenth century, it would appear that under melancholia there have always been grouped disorders which would now be diagnosed as catatonic or paranoid schizophrenia; paranoid conditions and paranoia; phobias and obsessive-compulsive disorders. Moreover, even within any one period the word melancholia held different meanings, depending upon the writer, with the

ONE of the four divisions of mental disorder formulated by Hippocrates, melancholia was defined by him as fear or distress persisting for a long time and having its origin in changes produced by the black bile. Although Hippocrates and the ancients of the school of Cos held, regarding its etiology, views which are not tenable today, they described the essential symptoms, namely, depression of mood, moroseness, grief and sorrow, insomnia, unreasonable fears, and the danger of suicide; the accounts also include such bodily changes as flatulence, dullness of the eyes, decreased motor activity, and careworn appearance. Throughout the centuries there have been innumerable attempts to improve the classification of mental disorders, but melancholia has invariably held a prominent position. Whether the classifications have depicted as few as the four divisions of Hippocrates or the twenty or



result that there was much confusion and misunderstanding. In an effort to remove some of the confusion, Adolph Meyer recommended that the term "depression" be used to cover the entire range of affective disturbances formerly grouped under melancholia, and he stressed the necessity for denoting, on a descriptive level, the particular kind of depression. This was in keeping with the teachings of Maudsley and Griesinger who stressed that the fundamental disorder was in the affective sphere and that intellectual changes, such as delusions, hallucinations, etc., followed the change in mood. Today, therefore, the place of "melancholia" in classifications is essentially historical and "depression" is now the current term.

Meyer believed that "the distinction had best be made according to the intrinsic nature of the depression," but he well realized the inadequacies of the then current psychiatric knowledge regarding the nature of depression. He advocated designation of types of depression according to etiology, symptom complex, course, and outcome, criteria which help descriptively but which cannot be fitted into any consistent pattern based on etiological knowledge. Further developments have led to even simpler classifications of depression, and such depressive states, for example, as those occurring in dementia praecox are no longer grouped nosologically with depression.

It was once held, and indeed still is by some, that the agitated depressions occurring in the involutional period are fundamentally different from other depressions, a differentiation based largely on the age of the initial episode, on the prepsychotic personality, and on the clinical picture. But again experience shows that similar clinical conditions may appear in early adult years and in old age, whereas the clinical picture of the manic-depressive depression may erupt for the first time in the decade of the menopause. In the recently published diagnostic manual of the American Psychiatric Association, involutional depression, over which so much controversy raged, has been discarded as a diagnostic category and it is now grouped with the psychotic reactions occurring in the involutional period and attributed to disturbances of metabolism, growth, nutrition, or endocrine functions. Yet there is considerable evidence that these disorders are primarily psychological reactions to stress—the stress of approaching change in the physical status, and with this the change in the individual's evaluation of herself and her capacities. It is true that disturbances in

endocrine function may initiate the physical changes, but it is the psychic reactions to these changes rather than the biochemical alteration in hormone production directly affecting psychic functioning which appears to constitute the psychoses.

There are three main categories of depression: namely, manic-depressive, psychoneurotic, and psychotic depressive reactions, the latter two being differentiated only by the severity of the clinical picture. Intrinsically this sort of differentiation is based on certain presumptions—there is implied, for example, the belief that manic-depressive reaction is a constitutional disorder, while the psychoneurotic and psychotic depressions tend to be precipitated by exposure to stress. It should be noted, however, that many a manic-depressive depression appears to have been precipitated by exposure to stress, while the picture of simple neurotic depression frequently occurs without any evidence that it is a reaction to stress. In this latest diagnostic manual great emphasis is laid on the premorbid personality, even as Hippocrates pointed up the susceptibility of individuals with a certain temperament. Of course in the last fifty years a great deal of research has gone into study of temperament and physical constitution pointing up certain frequently recurring factors. The manic-depressive constitution has been associated with the cyclothymic temperament and a short-necked, rotund body; while one of the criteria for diagnosis of involutional psychotic reaction is that of the obsessive-compulsive, conscientious and perfectionistic premorbid personality. Though the degree of correlation between types of premorbid personality and the clinical pictures is often significant, it is still low enough to indicate that other important factors, some perhaps as yet unknown, frequently play a more important role.

When we examine the purely reactive depressions, that is, the psychoneurotic and psychotic, the absence of recognizable environmental stress is on occasion striking. In fact, examination of a series of such patients shows considerable gradation in the degrees of stress which has provoked the reaction. To account for differing opinions concerning the importance of stress, it has been suggested that, since the examiner makes the diagnosis, he tends to utilize as a criterion the severity of the trauma as it would seem to him were he the patient. Even assuming this to be true and the diagnostician ever so sensitive, there remain a fair number of patients who appear to react in a way out of proportion to

the precipitating factor. In these cases it has been argued that the event has a much greater symbolic significance for the individual than is apparent to the observer—a viewpoint undoubtedly true in many cases but not helpful in classifying disorders.

It can be seen, therefore, that even from this limited view of depressive states, our present-day classifications are based upon a number of differing criteria which do not allow any true etiological differentiation. Diagnostic classification of mental disorders would be of maximum usefulness if of prognostic and therapeutic value, but it is well to remember that we have not yet achieved this millennium. In practice the diagnosis of depression carries with it prognostically a relatively benign connotation (provided that early and prompt treatment is instituted), a connotation which derives originally from the Kraepelinian formulation that manic-depressive depression is self limiting and recovery inevitable. However, it should be remembered that other emotional illnesses, often ushered in by episodes of depression, do not carry the same favorable outcome. It might be well to remember also that such competent observers as Guislain and Griesinger believed that depression was frequently present in the early stages of all types of mental disorders, and the necessity for early evaluation and treatment is, therefore, emphasized.

#### AFFECT

Most people experience some form of depression for brief periods of time, describing themselves as out of sorts, feeling blue, or dissatisfied with life, but such episodes are usually of short duration. The diagnosis of depression as a clinical entity should be made only when the disorder of affect is persistent, predominant, and apparently the primary change, though there may be fluctuation in range during the course of the illness and even during the course of the day. Furthermore, the affect is definitely painful and the patient complains about it. A semantic difference between "melancholia" and "depression" is very often brought out in examination of depressed patients. In melancholia the idea of sadness is to a large extent implied, and though some patients do say that they feel sad, however, a greater number deny this when questioned. More often the complaints are of feeling "low," "miserable," "horrible;" frequently there are complaints of confusion, of inability to think or concentrate, or of not being able to feel at all; but whether or not due to wide-

spread infiltration of medical terms into the popular vocabulary, many patients complain simply of feeling depressed.

Manifestations of anxiety are so frequent as to be almost universal in depression, encompassing such complaints as feelings of nervousness and inadequacy (especially when called upon to face some task which, no matter how simple, the patient feels incapable of undertaking); feelings of restlessness and general uneasiness, apprehension and fear. In the agitated depressions the anxiety may be the most overt manifestation of disordered affect. Moreover, the physiological accompaniments of fear and anxiety produce conspicuous symptoms, which will be discussed further under bodily changes. With depression there is an almost universal seeking for reassurance, even paradoxically in the severe states in which the patient appears convinced of the hopelessness of his situation. In some cases of schizophrenia there may be marked depressive coloring, coupled with anxiety, but whereas the depressed person is concerned about his future, the schizophrenic is anxious about his present state. There is, moreover, this important difference between the two conditions: namely, that in depression there is congruity between the mood and the mental content, the mood being consistent with the beliefs expressed by the patient, whereas in schizophrenia the affect is inappropriate to the content of the verbalizations.

In addition feelings of guilt are extremely common. The patient is full of self reproach, accusing himself of acts and deeds which he considers morally wrong. There is self recrimination for the commission of "the unpardonable sin," which may in fact vary from a minor breach of social rules to the most serious transgression of the Decalogue. It is perhaps unnecessary to stress that these ideas and beliefs are expressions of the cultural and social background of the patient and of the experiences and interpersonal pressures to which he has been exposed from infancy onward. Sometimes the history verifies, in some measure, the offenses of which the patient accuses himself, but more frequently the content of the accusations appears to have delusional force.

#### DELUSIONS

Disturbances of thought content occur much more frequently than is commonly recognized, and many statements by the patient which are accepted on



their face value as correct are in fact true delusions. These are associated mainly with three spheres of human values: namely, health, wealth, and moral worth. Under lack of moral worth has been mentioned the patient's belief that he has failed to live up to a moral code and that he has been guilty of transgressions. It is easy for the observer who is also subject to the same cultural system of values to understand the feeling that we call "guilt" that may arise from real or imagined breach of the moral code. However, for the patient whose sense of values has been acquired in a family background in which great emphasis was placed on health and bodily functions, feelings of lack of worth are readily manifested in hypochondriacal delusions. The great emphasis which our society places on adequate physiological functioning—witness the use of the pressure in advertising—probably helps to account for the frequency of the hypochondriacal complaint. Likewise an individual who has been exposed in his early development to parents to whom wealth and possessions are all important, he will, when he develops a depression, experience the distress in association with delusions of poverty. I would like to emphasize at this point that the dynamics involved are much more complicated than indicated by the simple description above.

Varying with the severity of the clinical condition, there may be simple feelings of inadequacy on the job or in managing affairs, or more typically in the material sphere may occur such symptoms as the patient's belief that he is poverty stricken, having lost his business or his home, or in the case of a housewife that there is not enough food to feed the family tomorrow, even though the refrigerator is full today. Hypochondriacal delusions are particularly varied; the gastro-intestinal tract is probably the greatest source of reference, with complaints of constipation, indigestion stoppages, pain, etc. The next most frequent source of reference is the genitalia, many patients showing evidence of sexual preoccupation; but, any physiological system may be the focus of attention.

Nihilistic is the adjective applied to delusions in which the patient may deny the existence of the world or anything in it, or of himself or parts of himself; he has no heart, no bowels, no feelings, nothing. This syndrome of negation, the syndrome of Cotard, is certainly more common in patients who develop psychotic illness during the involutional

period, but symptoms of this nature may be found in depressions occurring in other periods of life.

Ideas of reference and paranoid delusions, contrary to general impression, are present in more than 50 per cent of patients suffering from depressive states. Feelings of worthlessness, for example, represent the attitude of the patient toward himself, but the projection of this attitude onto others may occur so that he believes he is disliked or held in contempt by others. Likewise attitudes arising from beliefs of loss of money and possessions may be projected in patients who value economic success, so that they believe they are scorned by those they would wish to emulate. Starting with such premises, secondary elaborations may occur, and in such cases the patient's attitude toward the imagined hostility is one of acceptance because he believes it justified and himself deficient. However, there are patients who are completely unable to account satisfactorily to themselves for this rejection, and they are very resentful and hostile in a typical paranoid fashion. The patient may have paranoid ideas varying from simple belief of attitudes of hostility by others to belief that he will be persecuted, even imprisoned or killed. It should be mentioned here that even in the delusions of the depressed, there are often indications of a grandiose self evaluation; thus the patient declaims that he is the most evil person in the world or currently that a Senator from Wisconsin is investigating his background.

There is a large number of patients who show fluctuations in clinical condition so that at one time the affective change appears to predominate, with a lessening of paranoid trends; while at another time the paranoid trends become more prominent, accompanied by overt hostility, while the depressive state appears less obvious.

#### MOTOR ACTIVITY

It is usually assumed that the presence of anxiety is accompanied by increased motor activity which may vary from simple restlessness to extreme and exhausting agitation. But that this is not in fact universally true can be discovered by examination of patients who have passed through retarded states. By retardation is meant inhibition of physical or psychic functions. In the physical sphere the patient has an awareness of a deceleration in his motor performance and of inability to undertake physical activity of which he is normally easily capable. He

tends to sit in the same position with a minimum of spontaneous movement, and can progress to a stuporous condition (seldom seen now because of electroshock treatment) in which the patient is apparently completely indifferent to his surroundings, is mute, neglectful of his personal hygiene, and requires feeding by tube. It is on occasion necessary to differentiate such stupors from similar schizophrenic conditions, some of the distinguishing features being that the mute depressive will sometimes talk with relatives, usually takes care of physiological functions, has a personal appearance suggesting utter misery, and is not completely indifferent to stimuli in the environment, such as the prick of a pin.

Retardation in a non interrupted depression tends to increase steadily from a relatively small beginning until the maximum degree of inhibition is reached, and then as the depression is apparently beginning to lift, so also does the retardation tend to clear. However, as will be emphasized later, the time at which the retardation is decreasing is one of the periods when the danger of suicide is greatest. In some patients the motor retardation is manifested by a slowness of speech and of response to questions; the replies, furthermore, tend to be monosyllabic.

Retardation in the psychomotor field is sometimes much more obvious than that in the motor. The patient complains of or manifests difficulty in thinking and in reaching decisions. For example, many women patients will state on questioning that when shopping they have had the greatest difficulty in choosing between two brands of a particular product, and that after spending many minutes in futile efforts they fail to make the purchase needed because of the difficulty in making the selection. Neglect of business or housework may next ensue as the depression deepens. There is definite poverty of ideation which is fairly obvious where spontaneous speech is greatly reduced, but the poverty of ideation, though less obvious, is equally a fact in agitated depressions in which the patient may appear to be quite voluble. Here examination of the content of the talk reveals preoccupation with only a few ideas which occur repetitively.

#### DEPERSONALIZATION

Feelings of depersonalization and derealization are frequently encountered, especially in the early stages of depressive states. By depersonalization is meant the experience of a change of personality so

that there is a sense of loss of affective response; the patient may feel that he is detached from his body, is like an automaton, has no emotion, is unable to experience pleasure from the things which once evoked such response, has a dead or numb feeling, and indeed he may believe that his body is changed or does not belong to him. At the same time there is no disorder of body image; he knows intellectually that it is his own body and though he may experience numbness and lack of feeling, yet he does in fact recognize stimulation of the senses. Derealization is the feeling that in some intangible way the outside world is changed, persons and objects are unreal, lacking their normal attributes. But again the patient perceives the external world as it is. There is, as some patients will say, the loss of an emotional bond with the environment. (These symptoms often have to be sought in order to be recognized.) Frequently, in spite of complaints of lack of emotion, the patient is much concerned with the subjective change, complains of his isolation and his difference from his normal state, and presents many of the hall marks of anxiety. Derealization and depersonalization when present do not always occur together; sometimes one alone is present. These symptoms may be relatively inconspicuous as far as the complaint of the patient is concerned, but sometimes an unusual feature is seen when after treatment by shock therapy the depression lifts, apparently completely, and the feelings of depersonalization and derealization become so predominant that the patient states he prefers the previous misery of his depression. It may be stated that these states of unreality occur in many psychiatric syndromes, including schizophrenia, hysterical reactions, in fatigue states, and often in adolescence—the latter without gross emotional disturbance.

#### SUICIDE

The most dramatic event of depression is of course suicide or attempted suicide. The frequency of successful suicide is such that it is now one of the major causes of death in the community. In recent years the number of deaths resulting from motor accidents in Connecticut has been almost equalled by the number resulting from *felo-de-se*, and it is probable that the latter statistical mortality rate is lower than actual. In every patient coming under observation it is imperative that the risk of self injury be evaluated. There are, unfortunately, no criteria, the application of which will universally



indicate when suicide will be attempted. Almost every patient will on questioning admit having had thoughts that life was no longer worth living. Many admit the wish to die and some admit having considered making an attempt. The majority, however, usually hasten to emphasize that they would never do it, sometimes because of moral and religious reasons, sometimes because of the consequences to their family. Nevertheless, such reasons cannot be accepted as justification for dismissing the risk, for the suicidal act is frequently the result of an impulse which is not controlled by these considerations. There is greatest risk: (1) when there is a history of previous suicidal attempts; (2) when there is a history of suicide or suicidal attempts in the family; (3) toward the beginning of the illness when the depression is deepening and before motor retardation has become marked; (4) when the patient definitely admits to a loss of desire to live and when he does not attempt to deny the possibility of suicide; (5) when the patient complains of failure in relationships or obligations to others, especially those close to him. In my own experience with patients who have made suicidal attempts while under my observation or whom I have seen immediately following such attempts, the presence of unreality feelings, coupled with even relatively mild depressive symptoms, appears to constitute definite susceptibility. The depth of the depression in itself is not a good index because motor retardation may be such that the intention even when present cannot be carried out. On the contrary, one of the periods of greatest danger occurs when the depression is beginning to lift and motor retardation is diminishing. It is at this time that precautions tend to be relaxed; yet the suicidal drive may still be strong and often manifests itself in positive action. One frequently finds that when a patient has made a definite but unsuccessful attempt, especially one of a violent nature, and has incurred physical injury, the depression disappears relatively quickly, an effect possibly related to alleviation of guilt feelings by the self punishment inflicted. Nevertheless, there are not a few patients who will make repeated attempts if permitted. Some patients report an obsessive type of thought telling them to commit suicide, but it is impossible to deduce from this whether or not an attempt will be made. I have been impressed also by the presence of paranoid trends in depressed patients who have tried to take their lives. There seems little doubt, however, that patients with suicidal drive

when placed in a protected environment appreciate the security and the precautions taken, for most of them will subsequently admit to the relief they felt at the time.

Familiar is the newspaper account of attempted homicide and suicide by the depressed person. The object of the aggressive act is always a person or persons very dear of the patient. When the aggressor survives, the explanation given is of the utter hopelessness of the future experienced by the patient, a hopelessness that sees nothing in life for himself or those he loves; and the homicidal act represents superficially an attempt to save the loved ones from misery and unhappiness. The ambivalence universally present in depression is well pointed up in these cases and in those of the suicidal pact.

The frequency of the loss of the desire to live and even of the occurrences of suicidal thoughts is so high that all patients in whom these occur cannot be hospitalized—nor indeed is this always necessary; nevertheless it would seem that many deaths by suicide could be prevented by the early application of therapeutic measures.

#### INSOMNIA

Disturbance of the sleep pattern is practically universal even though there are variations. Classically in depression with retardation and without considerable overt anxiety the patient is able to sleep easily on retiring for the night but awakening in the small hours of the morning is unable to return to sleep. Though wide-awake, feelings of fatigue are prominent, and no matter how uncomfortable the bed, the patient finds it difficult to arise and dress. The morning hours are in fact the worst period of the day for the patient, and there is progressive improvement so that the evenings are the least miserable and often the most active, the pattern being repeated each day. Likewise, difficulty in thinking and in concentration are worse in the morning, lessening toward evening.

On the other hand, a patient who shows overt anxiety may complain of inability to go to sleep until the early morning hours, although he tends to waken at an hour earlier than is his custom. One might remember here that patients with simple anxiety states also show difficulty in getting to sleep, though such patients tend to awaken late. In hospital practice one frequently hears complaints of only one or two hours sleep or even of no sleep at all night after night; yet sleep checks reveal that the

hours of sleep are usually greater in number than admitted by the patient. However, most depressed patients tend to be light sleepers, and it would seem that much of the disturbance is due to dreams which arouse anxiety; at least some patients who fear that they will not sleep are in fact afraid that they will; the source of the fear being the drives which manifest themselves in the dream content.

#### PHYSICAL SIGNS

Observation of the depressed and retarded patient reveals little spontaneous activity; the posture is huddled, the face is pale and sallow, there is accentuation of the facial wrinkles and of the eyelid folds; the hair lacks lustre, the tongue is coated, the breath is foul; there is a definite trend toward constipation. There is usually prominent loss of weight which is not adequately accounted for by the loss of appetite and consequent decrease in nutritional intake. Blood pressure tends to fall though the opposite is sometimes true. Parotid function is reported to be lowered during the depression and the foot temperature to be raised.

The physical concomitants of anxiety are frequently found in retarded depressions as well as in agitated states. Axillary sweating, palpitation, rapid pulse, pallor, tumor of the extremities, and even syncope on occasions may occur. These symptoms become more noticeable when the patient is exposed to stress and may be seen during interviews, but they may also be present as the patient sits alone contemplating the "causes" of his misery. In some instances, the complaints of the patient may center around these phenomena especially when hypochondriasis is prominent and the depression of mood less obvious.

#### INSIGHT AND JUDGMENT

Though not a universal rule, patients suffering from depression realize that they are ill and usually seek treatment. They feel they are not well, either physically or mentally, and they recognize the changes as being pathological. There is little impairment of intellectual functioning though difficulties may arise because of preoccupation with their unhappy state and of their delusional beliefs. It is to

be remembered that just as the manic patient may dissipate his financial resources because of his delusions about his wealth and his abilities, so the depressed patient, concerned with his ideas of economic loss, may make serious errors in the administration of his business. The patient may give an apparently factual account of this loss of capital or of bankruptcy, or business reputation, due to mismanagement of his affairs arising as the result of action by himself or others; and the depression may be attributed to the result of the changed economic position. Occasionally information supplied by the nearest of kin, for example, the wife, may appear to confirm the accuracy of the patient's statements and only careful inquiry from independent sources will reveal the falsity of the ideas. The judgment of the patient in areas of his activities not affected by the delusions may be completely intact. Depressions occurring in elderly people may produce a clinical picture very suggestive of organic impairment, memory changes both in recall and retention, inability to comprehend and to elaborate and a tendency to perseveration being extreme so that at first glance the use of shock therapy may be ruled out for fear of provoking further damage. In these cases a careful investigation will reveal that the results of apparent organic changes are due primarily to psychomotor retardation and to preoccupation.

#### CONCLUSION

No attempt has been made to discuss psychodynamics, prognosis, or treatment. The sole purpose of this paper has been to present an outline of the symptomatology occurring in depressive states. To my readers who are not practicing in the specialty, I hope the paper has been useful, and to those already familiar with all data therein contained, I offer my thanks for bearing with me.

#### RECOMMENDED READING

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## EXCHANGE TRANSFUSION RESULTS IN ERYTHROBLASTOTIC INFANTS

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## SUMMARY

In a series of thirty-two erythroblastotic children born alive, nineteen received exchange transfusions, and five died.

Follow-up of the fourteen children receiving exchange transfusion who survived the neonatal period from three months to five years disclosed two children suffering from spastic disease who are alive, and one child who died of acute leukemia at the age of eighteen months.

In our experience a hemoglobin below 12 Gm., and a nucleated red cell count above 20,000 per cc. immediately after birth are unfavorable prognostic signs and indicate a fatal outcome in spite of exchange transfusion.

We have not found that the level of the anti-rh titer before birth provides a definite prognostic sign of development and/or severity of erythroblastosis in the infant.

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THE first exchange transfusion at the Meriden Hospital in a case of erythroblastosis was carried out five years ago. The nineteen children who have been treated here by this form of transfusion provide a basis for the evaluation of the long term outcome, as well as the immediate result of this method and an opportunity to compare the results with those reported from other institutions. It also provides an opportunity to compare the results with those obtained in children treated with small transfusions without replacement and those who were untreated.

## REVIEW OF LITERATURE

The exchange transfusion was first advocated by Wallerstein<sup>1</sup> and because of its dramatic effects and the relatively high mortality at that time prevalent in erythroblastosis, it quickly came into general use with early reports of remarkable results. Seven children in Wallerstein's<sup>1</sup> series with an apparently grave prognosis responded well to exchange transfusions and lived without signs of kernicterus. Among Wiener and Wexler's<sup>2</sup> twenty-eight treated

children, sixteen had severe involvement which would almost certainly have been fatal. One of the most enthusiastic reports was that of Diamond<sup>3</sup> who demonstrated in severe cases a recovery rate in treated children of seventy per cent, contrasted with only ten per cent recoveries in untreated children.

Among the reports in literature of the results of treatment by exchange transfusion, crude survival rates varying from 100 per cent in two series of six and eleven cases, respectively, to 65 per cent in a series of 34 cases can be discovered (Table 1). Molony<sup>11</sup> reported a twenty-nine per cent mortality in a series of children with replacement transfusion compared to twenty-two per cent in those untreated. Van Loghem and associates<sup>14</sup> reduced their mortality rate by the use of exchange transfusion from sixty-three to twenty-two per cent, and Diamond<sup>3</sup> from ninety to thirty per cent. In spite of this outstanding improvement Diamond felt that more could be accomplished and suggested the use of female blood for the exchange. The advantages of this procedure have not been confirmed by others.<sup>15</sup>

TABLE I  
CRUDE MORTALITY RATE FOLLOWING EXCHANGE TRANSFUSION  
IN ERYTHROBLASTOSIS DUE TO RH SENSITIZATION

INVESTIGATOR	NO. OF		PER CENT
	CASES	DEATHS	MORTALITY
Brancato <sup>4</sup> .....	29	4	13.8
Wiener and Wexler <sup>2</sup> .....	106	18	17.0
Diamond, Allen, and Thomas <sup>5</sup> .....	347	61*	17.8
Bartel and van Loghem <sup>6</sup> .....	141	21	18.5
Tzanck, Bessis, and Buhot <sup>7</sup> .....	34	12	35.3
Raska <sup>8</sup> .....	22	4	18.2
Wallerstein <sup>1</sup> .....	41	8	19.5
Mollison and Cutbush <sup>9</sup> .....	30	7	23.3
Mustard and Fraser <sup>10</sup> .....	24	3	12.5
Molony <sup>11</sup> .....	45	13	29.0
Ginsberg and Feldman <sup>12</sup> .....	11	0	0
Shapiro <sup>13</sup> .....	6	0	0

\*19 cases of kernicterus, living or dead, are included

The various indications for exchange transfusion reported by different institutions are probably responsible for the wide range in survival rates which have been published. This is due to the fact that there has been no definite gauge for determining the severity of the disease and thus allowing accurate evaluation of the result. Molony<sup>11</sup> emphasizes the following indices to determine the severity of the erythroblastotic state.

1. The appearance of jaundice during the first few hours of life.
2. Palpable enlargement of the liver and spleen at the first physical examination.
3. Hemoglobin below 12 Gm. at birth.
4. The occurrence of 25 normoblasts for each hundred white cells on the first blood smear.
5. A moderate to strongly positive Coombs test.
6. Icterus index above 50 units in the cord serum.
7. Previous occurrence of erythroblastosis in another child of the same mother.
8. Cyanosis and rapid irregular respirations demonstrated not to be due to atelectasis.

Giving a value of one for each of the points present in any case, he classified those with one to two points as mild, three to four as moderate and five as severe. Under this scoring system forty-three per cent of his children subjected to exchange transfusions and thirty-three per cent of untreated children were severe cases. Brancato<sup>4</sup> bases his evaluation of severity on the following four criteria:

1. No abnormal obstetrical history and no previous blood transfusions.

2. Abnormal obstetrical history and/or blood transfusions.

3. History of previous child recovered from erythroblastosis.

4. History of previous children with fatal erythroblastosis.

Wiener considered the antenatal studies of Rh antibodies in the mother's blood, as well as of the Rh antibodies in the infant's blood as the most reliable indication of the severity of the disease. Allen, Diamond and Vaughn<sup>16</sup> employ the following criteria as indications for exchange transfusions:

1. Rh positive baby of a sensitized Rh negative mother.
2. Pallor.
3. Hepatosplenomegaly.
4. Presence of petechiae.
5. Edema.
6. More than 4.5 nucleated red cells per cc.
7. In the absence of clinical signs, a maternal titer in the Coombs test of 1:16 or over.
8. Prematurity.
9. Past history of serious or fatal erythroblastosis.

#### MATERIAL AND METHODS

In making this study the files of the Meriden Hospital Laboratory were scanned for instances of Rh negative female blood. The patient names were then checked in the Record Room to determine whether they were of pregnant or non pregnant women. The laboratory records of all Rh antibody titers and Coombs tests were then checked against this list. The determinations of the Rh factor in most instances have been made through the offices of the attending physician. All determinations of Rh antibody titers were performed in the laboratory of the Meriden Hospital, with titrations carried out both in saline and thirty per cent albumin dilutions.

The Coombs test is carried out ordinarily in cases where a previously determined antibody titer or the history of a previous erythroblastotic child has made the obstetrician suspicious of the possibility of erythroblastosis. In some cases Coombs tests were carried out following exchange transfusion to determine the efficacy of the treatment. The figures reported in this paper as the titer represent the highest measurable agglutination in 30 per cent albumin dilutions. In a few cases in the absence of previous history of difficulty or for other reasons, Rh determinations were not performed, and Rh antibody





TABLE III  
CASES OF CLINICAL ERYTHROBLASTOSIS NOT SUSPECTED BEFORE DELIVERY

NO.	PARA	GRAV.	HGB.	ICTERIC INDEX	COOMBS TEST	NRC MM <sup>3</sup>	THERAPY
1	I	II	12 Gms.	9.8		1820	500 cc. exchange transfusion
2	I	II	15 Gms.	Jaundice		2400	445 cc. exchange transfusion
		8 months Induction Pre-eclampsia					
3	II	II	16 Gms.			115,000	240 cc. exchange transfusion. Repeated small transfusions
4	II	II	11.6 Gms.		+	1560	Small repeated transfusions
5	II	II	13.5 Gms.		+	3780	3 small transfusions
6	II	II	10 Gms.		+	2560	500 cc. exchange transfusion
7	I	I	13 Gms.			230	262 cc., 478 cc. exchange transfusion
8	II	II	12.8 Gms.		+	900	Repeated small transfusions

TABLE IV  
THE SIZE OF THE FETUS AND MATERNAL TITERS IN THREE STILLBORN CHILDREN WITH ERYTHROBLASTOSIS

NO.	PARA.	GRAV.	TITER	
1	IV	IV	1:512	Stillbirth, 400 Gms.
2	I	II	1:512	Macerated fetus, 44 cm.
3	I	III	1:2048	Macerated fetus, 450 Gms.

The antibody titers of the children who died in spite of exchange transfusion were 1:32, 1:64, 1:512, 1:1024, and 1:2048. The corresponding hemoglobin values were 7.6, 11, 5, 13, and 17 Gm. The nucleated red cell counts from peripheral blood were 38,800, 11,900, 42,500, 21,600, and 5,200, respectively.

The crude survival rate in infants treated by exchange transfusion is seventy-two per cent, and the total crude survival rate for all erythroblastotic children born alive is eighty-two per cent. Compared to the survival rates previously reported these results rank with the best. There is no basis for comparison as yet, however, of the severity of the disease in all those who were transfused. There are two

cases in this series which may not have required exchange transfusion, and there are also others with high maternal antibody titers who would have received exchange transfusion in other institutions, thereby considerably improving the survival statistics. Finally, there is at least one case in this series where the transfusion itself is probably partly responsible for the mortality.

The anatomical findings in the dead children showed in all instances congenital hydrops and erythroleukopoiesis, but only one instance of kernicterus. This latter condition was found in a child whose hemoglobin at birth was 5 Gm. and whose peripheral blood showed 100,000 nucleated red cells. This child received an exchange transfusion of only 400 cc.

The determination of the icterus index and/or serum bilirubin was not carried out systematically in each child.

The amounts of blood used in the exchange transfusions varied from 240 cc. to 985 cc. The five children who died received 450 cc., 587 cc., 400 cc., 540

TABLE V  
THE CLINICAL AND LABORATORY FINDINGS IN SIX CHILDREN BORN ALIVE WITH ERYTHROBLASTOSIS WHO DIED IN THE NEONATAL PERIOD

NO.	PARA.	GRAV.	TITER	HGB.	NRC MM <sup>3</sup>	THERAPY	FINDINGS
1	II	II	1:32	7.6 Gms.	38,800	450 cc. exchange	No autopsy
2	I	II	1:64	11 Gms.	11,900	587 cc. exchange	No autopsy
3	I	III	1:512	5 Gms.	42,500	400 cc. exchange	Hydrops congenitus, Kernicterus
4	IV	IV	1:1024	13 Gms.	21,600 Coombs +	540 cc. exchange 381 cc. exchange	Hydrops congenitus Hydrops congenitus
5	III	IV	1:2042	17 Gms.	5,200		
6	III	III	1:8192	6.8 Gms.	28,600	Died within one hour before exchange	Hydrops congenitus



cc., and 381 cc. In the last child death occurred at that point during the transfusion.

#### FOLLOW-UP RESULTS

Of the fourteen children receiving exchange transfusions who survived the neonatal period all have done well except for two. One of these has cerebral spastic disease and is mentally retarded. This infant was delivered prematurely at 8 months following induction of labor because of pre-eclampsia in the mother. It showed a hemoglobin of 15 Gm. at birth, and 2400 nucleated red cells per cc. in the peripheral blood. Exchange transfusion of 445 cc. was carried out. This case emphasizes the increased tendency of the premature child to develop kernicterus or clinical evidence of this condition.

The other child was born with a hemoglobin of 9 Gm., and an icterus index of 47 units. There were 5 atypical mononuclear elements per cc. in the peripheral blood. It did well after an exchange of 485 cc., and a small supplementary transfusion carried out a little later. At the age of 18 months the child was admitted to the New Haven Hospital with a clinical picture of acute leukemia confirmed by blood examination, and died within a short period.

A third child was born with a hemoglobin of 18 Gm., an icterus index of 6.5, and a titer of 1:16, showed only 300 nucleated red cells per cc. Treatment was by repeated small transfusions. This child developed evidence of cerebral spasm which has been persistent.

#### CONCLUSIONS

In our experience, the level of the mothers anti-rh titer does not provide a definite prognostic sign of development of erythroblastosis in the infant. There are two children with comparatively low maternal titers, 32 and 64, respectively, who died in spite of exchange transfusion. There are three children whose maternal titers were 1:256, 1:512, and 1:1024 who did not show clinical evidence of severe erythroblastosis. These children are alive and well. On re-examination they have been found to be Rh positive. Another child with a maternal titer of 1:1028 received no therapy but subsequently developed a secondary anemia.

The maternal titers of the children who died in spite of exchange transfusion varied from 5,200 in the child with 17 Gm., to 100,000 in the child with 5 Gm. of hemoglobin, and were proportional to the anemia. In none of the children who lived either

with or without therapy was the nucleated red cell count over 20,000. Since the serum bilirubin and icterus index were not employed regularly in this hospital, the number of nucleated red cells and hemoglobin value at birth seem to provide the most reliable measuring for the severity of erythroblastosis in the newborn.

A hemoglobin below 12 Gm., and a nucleated red cell count above 20,000 are very unfavorable prognostic signs, and in our experience indicate fatality in spite of exchange transfusion. This is found illustrated in the instance of a child born with a hemoglobin of 6.8 Gm., and a nucleated red cell count of 28,600 who died shortly before the preparations for the exchange transfusions were completed.

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## THE ABUSE OF DRUGS IN ANESTHESIOLOGY

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I HAVE chosen as my subject "The Abuse of Drugs in Anesthesiology" because I think it is a good thing for us occasionally to pull up sharply in our headlong progress and to consider just where some of our so-called "advances" are leading us. The term "abuse" means misuse, and includes overuse, underuse, and wrong use. I really should call this talk just "abuse of drugs," because I feel that abuses which have crept into anesthesiology are only reflections of what is going on throughout the whole field of medical therapeutics, and that we are in an age of polypharmacy in which we and our patients are at the mercy of well intentioned, but overwhelmingly powerful, pharmaceutical manufacturers. But I hesitate to tread on any other toes than those of my fellow anesthesiologists.

My father was a homeopathic general practitioner and I had the advantage of being brought up in an environment where material doses of all drugs were viewed with suspicion. The little sugar pills which were the subject of much derision among our uninformed friends were to us the very essence of effective therapeutics. The Hahnemanian precepts that "large doses of drugs are harmful," and that "the proper dose of any drug is the smallest one which will effect a cure" were instilled into me long before I started the study of so-called "scientific" medicine. There may be much that is nonsense in the homeopathic *materia medica*, just as there is nonsense in every pharmacopoea, but the power of the infinitesimal is not sneered at today as much as it was fifty or sixty years ago.

What is happening today in the field of drug therapy? The medical profession is bombarded by

the commercial exploitation of vitamins, hormones, antibiotics, sulphas, antihistamines, sedatives, stimulants and all the rest of the weird assortment. But the bombardment to which the medical profession is subjected is nothing compared to the bombardment to which we subject our poor patients. There is not much nursing being done any more—the nurses are too busily occupied with syringes and needles, ampoules and vials, and the patient is glad to get out of bed to wash himself because his backside is too sore to lie on it any longer. He may have in addition a drug rash from penicillin, hemorrhages from heparin, proctitis from aureomycin, urticaria from a vaccine, sulpha dermatitis, chloromycetin agranulocytosis, and be in a state of shock from an overdose of cortisone. Listen to this for a therapeutic cocktail served out to a friend of mine a few weeks ago—an old lady of 86 with advanced myocardial degeneration and arteriosclerosis, osteoporosis and a compression fracture of a lumbar vertebra:

Multivite tablets b. i. d.; calcium A and vitamin D tablets b. i. d.; Methyl testosterone linguets 5 mg. b. i. d.; Roniacol 50 mg. q. i. d.; Digoxin 0.25 mg. daily; Aureomycin 50 mg. t. i. d.; intramuscular vitamin B daily, and a special high protein diet.

Fortunately for her peace and comfort the old lady had the good sense to die after two weeks of this exhausting regime. Every time I go into the Osler Library at McGill I imagine I can see Sir William's spirit stirring uneasily there in his ashes as the result of this kind of departure from common sense which we see every day in the wards of all our hospitals. Osler was not exactly a "therapeutic nihilist" but he was sufficiently skeptical about drugs not to push any treatment beyond its reasonable application. He would expect his students to know when to stop drugs or to avoid them, as well as



when and what to give—even if he had been privileged to prescribe the “wonder drugs” of today.

I hope I don't give the impression that I am decrying the use of all the new drugs. All I want to suggest is that even such a supposedly harmless drug as penicillin should be used judiciously and stopped when it is not producing the desired effect; that even vitamins can be harmful when they are poured into a patient indiscriminately; and that some of the intangible forms of therapy like good old-fashioned nursing and gaining a patient's confidence, and trying to remove his underlying worries may be more effective than the intramuscular needle or a whole assortment of pills.

But, as anesthesiologists we must use drugs. We can't just use hypnosis. Let us, then, try to understand something about how drugs work in the body. This has been a fruitful subject for speculation, for philosophical dissertation, for superstition, throughout the whole history of medicine. In recent years increasing knowledge of biochemistry and the study of cellular metabolism has brought to our ears a new vocabulary. We hear talk now of such things as substrates, enzymes and co-enzymes, cytochrome system, Krebs cycle, competitive inhibition, glycolysis, dehydrogenases, succinate and pyruvate.

“In recent years, biologists have emphasized the likelihood that a large part of the action of drugs upon cells can be explained largely by the action of the drugs on cellular enzymes. It may not be immediately apparent why this should be so, but reasons become clear enough if we consider the function of enzymes in cells.

“All of the chemical changes in the body are enzyme catalyzed. In the complex series of chemical transformations, the products from one enzyme become the raw material or ‘substrate’ for another. One may liken the metabolic organization of the body to a network of hollow tubing with fluid entering at various points at the periphery and escaping as by-products at others. Thus, by increasing the rate of inflow in any one point, clamping off any unit part of the system or obstructing even an outlet will alter the pressures and rates of flow to a greater or less degree throughout all parts of the network, depending on the proximity or remoteness from the point of obstruction. These interfering factors in metabolism may include deficiency or excess of any food material, electrolyte imbalance, dehydration, accumulation of water, anoxia, oxygen poisoning, cold, fever, foreign materials such as drugs, or other poisons and many other agents or conditions.

“Among the unit processes in the metabolic network are the enzyme systems of glycolysis, the tricarboxylic acid cycle, the cytochrome system, all of which go to make up the energy producing mechanism of the body. Numerous other enzyme systems are engaged in synthesis and degradation, in facilitating secretion and absorption, etc.”\*

Much of this to me as a clinician is quite incomprehensible as I am sure it is to most anesthesiologists and surgeons. But for me the whole science of enzymology does boil down to certain general principles in our conception of drug action:

1. The administration of every drug has an effect on some enzyme system.
2. The reversibility of this effect is usually dependent on the size and frequency of the dose of a drug.
3. On account of the infinite variety of biochemical processes in such complex organisms as the human body and the infinite variety of conditions found in one person as compared with another, there is great individual variation in the response to drug action.

I would like to discuss in a practical way the overuse, the underuse, and the misuse of drugs in anesthesiology. In my opinion, overdosage is a prevalent sin. Ether, for instance, is a safe and comparatively harmless drug, but when a patient is saturated with it for hours the enzyme systems take a beating. I hate to think about the patients we used to condemn to long periods of distressing disability when open drop ether was the sole agent employed in long major operations. Fluid imbalance, acidosis, visceral damage, tissue hypoxia and gastro-intestinal upset were the side effects we produced when ether was pushed to obtain complete muscular relaxation over long periods. Today we don't often see such damage because we don't use so much ether, but notwithstanding the eloquent arguments of Beecher, I still believe that an overdose of ether can be poisonous and that some of our patients in civilian and military hospitals are suffering from the abuse of this drug.

The case against overdosage with nitrous oxide is perhaps even more serious. This oldest and possibly least toxic of our anesthetic agents is enjoying a revival of popularity in the hands of many of our most expert and intelligent anesthesiologists. The advent of relaxant drugs has made possible the use of nitrous oxide for major surgery in combination with adequate oxygen. But the ever present danger

\*Quotation from unpublished thesis of E. A. Hosein, PH.D.

of hypoxia, even transient hypoxia, in the case of small children or feeble patients, should be in the forefront of our thought regarding nitrous oxide. I marvel when I watch the skill with which such experts as Clement and McCarthy walk along a narrow ledge with pure nitrous oxide-oxygen anesthesia. I am sure that in trying to avoid the pitfalls of inadequate anesthesia, duffers like you and me let some patients tumble into the even more serious abyss of hypoxia.

With cyclopropane there is little danger of, and no excuse for hypoxia, but overdosage may lead us almost imperceptibly into respiratory acidosis from insufficient elimination of carbon dioxide. Nothing is more important in the conduct of safe cyclopropane anesthesia than maintenance of adequate pulmonary ventilation. I need hardly emphasize to you anesthesiologists the deceptive danger of a ruddy complexion and excessively quiet respiration in a patient under deep cyclopropane. Efficient soda lime together with effective pulmonary ventilation are our essential safeguards against the onset of the condition which Dripps has described so classically as "cyclopropane shock."

When we talk about intravenous barbiturate anesthesia most of us wisely mean only very short anesthesia or the induction of anesthesia, and so it seems hardly necessary today to dwell upon the dangers of overdosage. Unfortunately, however, many doctors do not seem yet to have learned of the insidious dangers of barbiturates in shocked patients, in cases of respiratory obstruction, and in old people. Intravenous anesthesia looks so temptingly easy that inexperienced anesthetists are all too often confronted with respiratory arrest in a situation where they have no facility to cope with it. Pentothal should never be given in a concentration stronger than  $2\frac{1}{2}$  per cent because of the very real danger of intra-arterial injection, of venous thrombosis, and of cellulitis in a case of perivenous injection. My associate, William Cullen, last year made a study of all reported cases of disasters following intra-arterial injection of pentothal. So far as we could ascertain, in every case where gangrene resulted the concentration of the drug was 5 per cent or more. On the other hand, I have accidentally injected 8 cc. of a solution of pentothal in  $2\frac{1}{2}$  per cent concentration into an artery without any sequelae other than transient pain. Because the solution in  $2\frac{1}{2}$  per cent concentration will accomplish just as much as any higher concentration I

cannot see any justification for using higher concentrations. In old people all barbiturates should be given with caution, whether intravenously or by mouth. Elimination may be extraordinarily slow, and psychic reactions unpredictable. In all too many hospitals the story is a common one that an old person in a high and unfamiliar bed has been given a "routine" sedative either preoperatively or postoperatively. He goes to sleep, and then as customary nocturnal bladder reflexes become active he confusedly tries to get out of bed to relieve himself, just as he always does at home. The nurse hears a thump, and finds the patient on the floor with broken hip or bleeding nose. Such accidents occur because hospital personnel forget the confusing effect of barbiturates and other sedatives in old people.

I would like to dwell for a few moments on the question of proper dosage and overdosage of muscular relaxant drugs. All of these drugs, from curare to succinylcholine, are, as Gillies so aptly states, "physiological trespassers." They upset enzyme systems, their effect can become irreversible, and they may be classed as deadly poisons. One well known anesthesiologist thinks it his duty to go up and down the land preaching to surgeons that the use of relaxant drugs is little short of criminal. Suffice it to say that I do not agree with my distinguished friend. Even water may be a deadly poison if it is not used properly, and deaths from the relaxant drugs are almost always due to overdosage, improper use or abuse of some kind. In my judgment the physiological trespass involved in the proper use of curare or its allied products is entirely justified on the basis of ultimate benefit to the patient. There are, however, some people who do not understand the proper use of these drugs. In anesthesiology they are used for one purpose—to provide adequate muscular relaxation in a patient under an anesthetic. The proper dose is the smallest dose which will produce this desired effect under the particular circumstances of each individual case. One must take into account the size and muscular structure of the patient, the nature and the depth of the anesthetic agent, the nature of the operation being performed—and the nature of the surgeon. The more controllable we can keep the relaxation provided by curare-like drugs the safer they are—that is why I am very much interested in the newest one—succinylcholine. When this drug is given intravenously in a dilute solution of approximately 1 mg. per cc. for abdominal opera-



tions the rate of administration can be adjusted individually in such a way that one can practically turn muscular relaxation on and off at will. Succinylcholine is broken down by cholinesterase in the blood plasma so rapidly that when it is used intelligently there is no excuse for an overdose. However, reports in recent medical literature, particularly from Great Britain, indicate that it is being given sometimes in overwhelming doses and with serious consequences. Because some doctors are stupid in the administration of this or other muscle relaxants is no reason, in my opinion, entirely to condemn the use of these drugs.

In recent years there has been an increasing tendency for anesthetists to administer drugs in what Wesley Bourne calls "complemental combinations." Some have less euphoniously described the practice as the administration of "anesthetic cocktails." Beecher wrote an editorial in the *Annals of Surgery* saying that this is just an attempt by anesthesiologists to make a fundamentally simple procedure look difficult and therefore to make anesthesiology seem more complicated than it really is. The gist of his argument is that we can keep the whole business of anesthetic technique simple by using nothing but ether for everything we do. I do not agree that the administration of ether is always either simple or wise, but I think it is quite true that unnecessary combinations of drugs should be avoided. I do not believe, however, that many qualified anesthesiologists are guilty of that kind of charlatanism. By the judicious combination of agents we can often keep the dose of any one of them far below the level of irreversible toxicity, and guide the patients through really formidable surgical interventions with a minimum of physiological upset. One might just as well say "Let's go back to riding horseback because the modern automobile is too complicated and needs too skillful a driver."

I have some very firm convictions about overdosage in spinal anesthesia which I would now like to bring to your attention. I have seen a number of patients die under spinal anesthesia, rapidly and irretrievably. I am sure that in every case I have seen and in most of those I have heard about, the death was because the dose of anesthetic agent was too large for that particular patient. Patients vary in their susceptibility to drugs administered intradurally just as they do to drugs administered in any other way. It is difficult to estimate susceptibility in advance, and once an injection is made it is impos-

sible to withdraw it. We have adopted the plan of giving to every patient for spinal anesthesia the very smallest dose which we feel will be effective, and we use dilute hypobaric solutions in preference to concentrated heavy ones. For a hysterectomy, for instance, we use never more than 10 mg. of Pontocaine in 10 cc. of distilled water, and for a vaginal delivery 50 or 60 mg. of Procaine in a concentration of 1.0 per cent. This means that in some patients who are resistant to subarachnoid drugs the spinal anesthesia is a failure—but a failure is not so serious as a fatality. Now that we have relaxant drugs it is a simple matter to change one's technique when a spinal anesthetic is ineffective. The result of adhering to this principle of minimum dosage is that in my practice we now use spinal anesthesia very much more frequently than we did some years ago. I am enthusiastic about its advantages and its safety in a large proportion for our anesthetics for gynecologic, for urologic, for thoracic surgical procedures and in obstetrics. There are, of course, other safeguards one must employ for safe spinal anesthesia, but I am talking now only on the subject of dosage. In so far as its use in obstetrics is concerned, I am convinced that smaller doses of agents administered intraspinal should be used than for a similar degree of anesthesia in general surgery—just why this is so, I am not sure, but by remembering and teaching this fact we can avoid an occasional disastrous accident.

When we come to consider pre-anesthetic medication one can point out frequent instances of both overdosage or underdosage. In one of his best aphorisms Wesley Bourne has said, "The purpose of pre-medication in anesthesia is to obtund, to obfuscate, and to obnubilate." In other words, really to sedate the patient is more important than drying up secretions or other incidental effects. Many anesthesiologists and surgeons are far too timid about pre-operative sedation, and they let a patient arrive in the operating room in an unreasonable state of agitation just because they have a theory that this or that sedative is too depressing to the heart or to respiration, or some such notion. Depriving the patient of the psychological effect of adequate preoperative sedation may make the whole anesthetic procedure doubly difficult, and even lead to prolonged psychic trauma. This is perhaps particularly true with children who are certainly entitled to as much well chosen sedation as are adults. Over sedation is of course also possible, and I have mentioned how this may result in accidents in old people. My personal

observation is that hypnotics, such as the barbiturates, chloral hydrate or scopolamine, are better preoperative sedatives than drugs like morphine, codeine, and demerol which are primarily analgesics and should be kept for postoperative use when pain is a factor. The dosage and the time of administration should be matters for individual assessment and not routine prescription. One should remember how easy it is to oversedate old people, and how easy to undersedate children.

While we are talking about the underdosage of drugs I would like to mention one other situation in which I think this often occurs. To use curare or other relaxants satisfactorily and safely one must set up in the patient a delicate and shifting balance between anesthetic agent and relaxing agent. When the patient shows evidence of reaction to painful stimuli, whether by muscular movement or alterations of respiration, it is the anesthetic agent which should be given in increased dosage. None of the relaxing agents has any analgesic or hypnotic effect when given within the range of clinical dosage, and all too often I have seen anesthesiologists attempt to conduct an abdominal operation with too much relaxant and not enough anesthetic agent. Under such circumstances who knows what turbulence may result in the reflexes and enzymes of the immobile but poorly anesthetized patient. So I say, if one is going to use curare or other relaxant drugs, for goodness sake see that the patient is adequately anesthetized!

There are other examples of the misuse of drugs in anesthesiology, such as depending on pentothal for analgesia in painful operations when some more effective analgesic agent should be used, or trying to obtain muscular relaxation with trichlorethylene, or expecting to relax a uterus with cyclopropane when chloroform is the proper drug to use. But the misuse of drugs which I would like here to emphasize is the abuse of sedatives to patients in the first stage of labor. I do not believe the doctrine that amnesia is the desired goal of American women in regard to the whole experience of labor. Amnesia, as the result of drugs, is not a difficult procedure but this certainly is often obtained at the expense of the newborn baby and possibly with subconscious psychic trauma to the mother. Without going in for all the prolonged training period and the hypnotic suggestion advocated by Grantly Dick Read, I do believe one can make the experience of labor rewarding and tolerable by a program of common sense, cooperation between patient, obstetrician,

nursing staff, interns, and anesthesiologist. Intelligent reassurance, friendliness, and gentleness can often be so effective in keeping up a patient's courage and morale that few drugs are needed. The presence of a skilled anesthesiologist or an understanding and experienced anesthetic technician is of importance to a woman in labor in order to give her reassurance that help is available should the pains become intolerable or any complications develop. If the obstetrical team will take the trouble to individualize patient care during the first stage of labor, there will be very little need for massive doses of sedative drugs. Small, individually prescribed doses of morphine, demerol, or of the barbiturates can accomplish wonders when combined with an encouraging psychological approach. Intravenous alcohol we have found to be useful in patients who may be discouraged and exhausted from long ineffectual labor pains. When administered in proper dosage it gives the mother a rest, raises her morale, and has few of the depressing effects or other disadvantages of commonly used sedatives.

I have not said anything about the controversial use of hypotensive drugs and their possible effects on enzyme systems, or about the therapeutic use and abuse of carbon dioxide, or about the overloading of circulatory systems (particularly in children) with intravenous fluids of all kinds, or of using the wrong kind of solutions in an attempt to maintain electrolyte balance, or about the use and abuse of analeptics.

To summarize my views about the abuse and the proper use of drugs in anesthesiology I would like to leave with you these three guiding principles:

1. The proper dose of any drug is its smallest effective dose—that means the smallest dose which will accomplish the effect we desire in a particular patient.
2. When we have a choice of drugs the best ones to use are those which are most controllable and most rapidly eliminated.
3. We should individualize therapy for our patients and never prescribe by routine.

To follow these principles we must be prepared to use common sense, to exercise our brains, and to act like the highly trained specialists which we take so much pride in calling ourselves. But we should make sure that our specialization is on a broad basis which includes consideration for human relationships and social backgrounds as well as basic sciences and anesthesiologic techniques.



## TEAMWORK IN PUBLIC HEALTH

### The Physicians Viewpoint

THOMAS P. MURDOCK, M.D., *Meriden*

**I**N THE beginning let me say that despite a very heavy and tight schedule I am grateful for the opportunity of participating in this discussion. I come here as a private practitioner of medicine and not as a member of the Board of Trustees of the American Medical Association. In the past few years, however, I have begun to wonder whether or not I am a private practitioner of medicine.

Last December I was privileged to address the National Association of State and Territorial Health Officers in Washington, D. C. At that time I stated that I detected a weakness in their program in that there were no avenues available for bringing their programs or the results of their programs to the state level and if there were none, some of their efforts were being wasted. And so today I am particularly pleased with this program and your efforts.

I am sure you realize, as I do, that there are some practitioners who feel that the Public Health officers have usurped some of their prerogatives. In some instances this is probably true, in general probably not.

It is now known, recognized, and even might I say accepted that the base line of Public Health has been greatly widened. At the turn of the century the duties of the Public Health Officer were those of quarantine officer and sanitary officer. The field now covers almost every phase of the healing arts as your program indicates today—and includes medical, dental, nursing, and social service coverage.

In the medical field practically all of the chronic illnesses are included. At once I think of chronic arthritis, cancer, rheumatic fever, syphilis, diabetes, crippled children and several others. This makes the situation particularly dangerous and tends to increase the tensions between the Public Health officers and the physicians. Some practitioners are bound to say that the Health Officers have usurped their position.

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The Author. *Trustee, American Medical Association*

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#### SUMMARY

The base line of Public Health has been greatly widened to cover almost every phase of the healing arts. There is a feeling on the part of some physicians that the Public Health Officers have usurped the position of the practitioner in the chronic illness program. The increasing prominence of nurses and social service workers in the Public Health field may create difficulties. Such conflicts must be solved. Voluntary practice must not be crowded out by federal programs.

Tolerance on the part of the physician and of the Health Officer is urged as well as care in the selection of personnel by Health Officers at the top level. The care of the sick is the common purpose of both physician and Health Officer.

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The fact is that when Federal funds are to be allocated for these purposes, the chief, if not the only Federal allocating authority, is the United States Public Health Service and in most of the states, the only allocating authority is the State Department of Health. Because of this set up, rules and regulations are formulated at the top, and the implementation is accomplished at the state level. The fitness of things at the local level are frequently different, and this makes for trouble.

During the past year the dispensation of gamma globulin was added as one of the duties of the Public Health officers. As you know, there was thought to be a shortage of this material in this country. I happen to have been a member of the National Allocation Committee, actually a sub-committee of the National Research Council. It looks, at this time, as though there will be a surplus

when the severe polio season is over rather than a shortage. I was opposed to this additional burden on the Health Officers because it immediately placed the Health Departments on the spot. My opposition also was based on the fact that confusion still exists as to the best method of application. There are those who believe that mass immunization alone is effective, while others believe that the best approach is by attempting to stimulate antibodies of intimate contacts. Time alone will probably tell which is the proper approach.

I have great respect for American nurses and this, of course, includes the Public Health nurses. Public Health nursing standards are high and should be kept so. They have filled a prominent place in the healing arts team. Here again I detect the beginnings of some rows between the different grades of nurses, and between the physicians and the nurses. These differences must be recognized and solved if we are to avoid continued bickering.

The Social Service worker, and more particularly the medical Social Service worker, is relatively new in the health field. If the philosophy behind this service is sound, and I believe it is, there will be greater opportunities for young women in this field than ever before due to increasing life expectancy and to increasing numbers of people with long duration illness. However, there is danger here also, and I have heard Social Service workers called meddlers. This is unfortunate because I believe they have a definite place on the modern healing arts team. However, they should be carefully selected and have a thorough knowledge of medical ethics.

You must not think that I have gone beyond my allotment in this program, by touching briefly on nursing and social service workers. Actually, I have done so purposely to bring out possible dangers.

As I view it, from here on the Public Health Officer is on dangerous ground. He must carry a greater load than ever before and over places where the ice is very thin. First—the conflicts that may develop between the physicians and the Public Health Service—these should be prevented if possible. Second—there is danger of creeping socialism or creeping nationalism if the Public Health Service is not wisely administered. American medicine should not, and I am sure will not, give up on the question of voluntary practice. Medical care by compulsion would be intolerable.

The American Medical Association has taken the

stand that it is proper for the state to provide a subsidy for a long duration illness and, in the case of veterans, for the Federal government to do it until the various states can make such provisions. I am in complete agreement with this position.

I make two major recommendations: first, tolerance on both sides. The practitioner not to attempt usurpation of the Health Officers field and the Health Officer not to usurp the field of the practitioner. There is room and there are places for both. Secondly, very great care should be used by Health Officers at the top level in the selection of the personnel below. This, I believe, is extremely important. If the field officer, who has contact with the physician directly, is intolerant or officious, a breakdown in public relations takes place and this widens the breach. If these two points are followed, a great many differences will fade or will not appear. After all, our purposes go hand in hand, namely, the care of the sick and the prevention of disease.

The time has come, I believe, when greater stress must be placed on these problems in our medical schools and in our Public Health schools. A great many of the differences will be prevented if this can be accomplished. Also if the practitioner had a clearer concept of the duties of the Health Officer and the Health Officer a clearer concept of the physician's position, these difficulties could be prevented. This applies particularly to those who are new in the healing arts field. Those of us in the evenings of our days can be safely ignored.

Here in Connecticut we are very fortunate in having as our present State Health Commissioner, Dr. Stanley Osborn. We are equally fortunate in having Dr. Ira Hiscock as head of the Public Health School at Yale University. Both have had very close contact with the practitioners in this State and, probably because of this, our problems and differences have been minimal. You must remember, however, that I am somewhat biased because both of these men have been my very close friends down through the years.

Finally, our purposes and aims are the same, namely, the care of the sick, the prevention of illness and the betterment of public health. I am sure that any of the other professions or businesses in life would give all for such noble basic purposes. Let us continue to work together here in Connecticut, and carve a pattern that will blaze a trail for the other states.



162nd ANNUAL MEETING  
of the  
Connecticut State Medical Society

BULKELEY HIGH SCHOOL, HARTFORD

April 27, 28, 29, 1954

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PROGRAM COMMITTEE

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LOCAL COMMITTEE ON ARRANGEMENTS

STEWART P. SEIGLE, *Hartford, Chairman*

SIDNEY L. CRAMER, *Hartford*

JAMES S. MISSETT, *Hartford*

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P R O G R A M

Tuesday, April 27

AUDITORIUM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLE B. GIBSON, *Meriden, Speaker of the House, presiding*

10:00 CALL TO ORDER

BUSINESS SESSION

1:00 Luncheon for Officers, Members of the House, and Guests

2:00 Resumption of business

7:00 ANNUAL DINNER OF THE COUNCIL—Tumble Brook Country Club, Bloomfield

## Wednesday, April 28

## AUDITORIUM

9:00 REGISTRATION—Exhibit Hall

9:15 MOTION PICTURE FILM

9:30 CALL TO ORDER—President of the Society

ADDRESS OF WELCOME—President of the Hartford County Medical Association

H. M. MARVIN, *New Haven, presiding*

10:00 MEDICAL MANGEMENT OF HYPERTENSION

Henry A. Schroeder, *St. Louis, Missouri*

10:35 DIAGNOSIS OF CHEST DISEASES

Edward J. Welch, *Brookline, Massachusetts*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

RALPH E. KENDALL, *Hartford, presiding*

11:40 SUDDEN DEATH

Lester Adelson, *Cleveland, Ohio*

12:20 CLINICAL APPLICATION OF RADIOISOTOPES

Lee E. Farr, *Upton, Long Island, N. Y.*

1:00 LUNCHEON, Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

## PROGRAM BY HARTFORD HOSPITAL

2:00 Historical and Clinical Meeting Commemorative of the Founding of the Hartford Hospital in 1854

THE HISTORY OF THE HARTFORD HOSPITAL

Stanley B. Weld, *Visiting Obstetrician and Gynecologist, Hartford Hospital*

INCIDENTS AND ANECDOTES OF THE HARTFORD HOSPITAL

Robert A. Goodell, *Honorary Staff, Hartford Hospital*

2:45 CLINICOPATHOLOGICAL CONFERENCE

Departments of Pathology and Medicine



Wednesday, April 28

ROOM 169

HUGH K. MILLER, *Stamford, presiding*

10:00 HEMORRHAGE, A FOREMOST PROBLEM IN OBSTETRICS

Duncan E. Reid, *Boston, Massachusetts*

10:45 TRANSFUSION REACTIONS

Alan Richardson Jones, *Boston, Massachusetts*

Discussion opened by Daphne Richardson Jones, *Boston, Massachusetts*

11:30 INTERMISSION TO VISIT TECHNICAL EXHIBITS

MARVIN LILLIAN, *Bridgeport, presiding*

12:00 ACUTE RENAL SHUTDOWN AND THE ARTIFICIAL KIDNEY

Roy C. Swan, *New York*

1:00 LUNCHEON, Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

## MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

TENTH ANNUAL MEETING

President: Mrs. Dewey Katz, *Hartford* Secretary: Mrs. Stevens J. Martin, *Hartford*

Program and location of meeting to be announced in April JOURNAL

3:30

Section on Anesthesia

Section on Dermatology

Section on Gastroenterology

Section on Proctology

Section on Radiology

Association of Medical Examiners of Connecticut } Joint Meeting  
Connecticut Society of Pathologists }

Connecticut Association of Medical Record Librarians

Connecticut Branch of American Association of Medical Social Workers

Connecticut Occupational Therapy Association

Connecticut Regional Group, Medical Library Association

Connecticut Rheumatism Association

7:00 ANNUAL DINNER OF THE SOCIETY—HARTFORD CLUB, HARTFORD

Thursday, April 29

AUDITORIUM

9:00 REGISTRATION—Exhibit Hall

9:15 MOTION PICTURE FILM

JOHN F. NOLAN, *Bridgeport, presiding*

10:00 RECURRENT INTESTINAL OBSTRUCTION

Victor P. Satinsky, *Philadelphia, Pennsylvania*

10:35 To be announced

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

STEVENS J. MARTIN, *Hartford, presiding*

11:40 CARDIAC ARREST

Hugh E. Stephenson, Jr., *Columbia, Missouri*

12:20 SURGICAL TREATMENT OF CORONARY INSUFFICIENCY

Arthur M. Vineberg, *Montreal, Canada*

1:00 LUNCHEON, Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

2:00 DISEASES OF THE BILIARY TRACT

Program being arranged by Connecticut Society of American Board Surgeons

ROOM 169

9:15 MOTION PICTURE FILM—ORAL CANCER: THE PROBLEM OF EARLY DIAGNOSIS  
(Courtesy American Cancer Society—Connecticut Division)

N. WILLIAM WAWRO, *Hartford, presiding*

10:00 PLASTIC AND RECONSTRUCTIVE SURGERY

Richard H. Walden, M.D., D.D.S. *Hempstead, New York*

10:45 THE CONTRIBUTION OF THE ORAL SURGEON

Daniel J. Holland, Jr., D.M.D., *Boston, Massachusetts*

11:30 INTERMISSION TO VISIT TECHNICAL EXHIBITS

NORTON CANFIELD, *New Haven, presiding*

12:00 THE TREATMENT OF SPEECH DEFECTS FOLLOWING SURGERY

G. Paul Moore, PH.D., *Evanston, Illinois*

1:00 LUNCHEON, Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS



Thursday, April 29

SYMPOSIUM ON DIABETES

BURDETTE J. BUCK, *Hartford, presiding*  
President, Connecticut Diabetes Association

2:00 HORMONAL CONTROL OF DIABETES

C. N. H. Long, *Sterling Professor of Physiology, Yale School of Medicine, New Haven*

3:00 PANEL DISCUSSION

C. N. H. Long, *New Haven*

Burdette J. Buck, *Hartford*

Samuel Donner, *Hartford*

Barnett Greenhouse, *New Haven*

Mrs. Alice Scanlon, *Diabetic Supervisor, Hartford Hospital*

There will be a discussion of the diagnosis of diabetes, the Diabetic Clinic, the Hospital Diabetic Service and the teaching of the diabetic in the hospital. This will be followed by a question period.

3:30 MEETING OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

Eye, Ear, Nose, and Throat Section

The Connecticut Society of American Board Obstetricians and Gynecologists, Inc. } Joint  
Section on Obstetrics and Gynecology } Meeting

Section on Orthopedics

Section on Physical Medicine

Connecticut Society for Psychiatry and Neurology

Section on Urology

Connecticut Chapter, American Physical Therapy Association

Hezekiah Beardsley Pediatric Club

Connecticut Rehabilitation Association

Complete information concerning the meetings of the Sections of the Society has not been received in time for publication in this issue of the JOURNAL. These programs will be printed in the April issue.

ART EXHIBIT

CONNECTICUT PHYSICIANS' ART ASSOCIATION

Exhibit Committee

Mrs. Louis Spekter, 23 Vineland Terrace, Hartford

Frederick W. Roberts, 158 Whitney Avenue, New Haven

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### The Turn of the Road

To many a man and woman retirement from an active life means the end of the road; to many others it offers an opportunity for the pursuit of some hobby, some long desired avocation which yields no financial return but a wealth of happiness. The citizen of the United States is being impressed daily with the magnitude of this problem of growing old and with its corollary, retirement pensions. Persistent headlines in current magazines point up the facts. During the past 50 years the proportion of persons over 45 years of age in the total population of this country increased from 18 to 28 per cent and the proportion of persons over 65 years of age doubled in numbers. Statisticians tell us that within the next 20 years persons over 45 will constitute one-third of our population.

The daily press reminds us that retirement plans now are a proper subject for collective bargaining. Following the decision of the Labor Relations Board establishing such a policy, industry has hastened to adopt pension plans, preretirement health or education programs and postretirement contracts. The tendency now much more than formerly is to cover hourly-rated employees and to establish plans which do not require direct employee contribution and which do offer some coverage for disability cases.

Why should we in Connecticut be particularly interested in this problem of growing old? It is a fact that while all the other New England and Middle Atlantic States have been losing older people through migration, Connecticut has been acquiring

increased numbers in this group. The population over 65 years of age in our State increased twice as fast during the decade 1940 to 1950 as did the population in the State as a whole. Likewise the increase in this elderly group was much higher in Connecticut than in the entire nation.

Both industry and government are showing an interest in this problem. One group of Connecticut industrialists, the Naugatuck Valley Industrial Council, Inc., recently devoted its entire one day program to discussing "The Problem of Older Management and Operatives in Manufacturing Industry." Governor Lodge has appointed the new State Commission to Study the Potentials of the Aging, and for this commission has selected such experts as Professor Waugh of the University of Connecticut, Elmo Roper, public opinion analyst, Mrs. Fleur Cowles, journalist and publisher, and Stanley High, roving editor for *Readers Digest*.

Studies have been made of current practices of industry in caring for the aging employee. Notable among these studies is the one completed by Dr. Laurence J. Ackerman and Professor Walter C. McKain, Jr., both members of the University of Connecticut faculty. The pension movement is on the march, in fact, since World War II it has been flying with the speed of a Pegasus. The University of Connecticut study points out some of the important factors which must be considered by individual industry in creating an adequate program. One of the more intricate problems to be faced is that of determining the normal retirement age and



setting up policies regarding mandatory or optional retirement. A glaring inconsistency exists in the higher age fixed for male workers over female, although the life expectancy of women is greater and they are normally employed in jobs which are less demanding physically.

All of this must interest the physician because he, like every other human being, grows old and should be able to look forward to a comfortable retirement, if and when such a day comes. Organized medicine is opposing compulsory social security coverage for the physicians of our country. The return appears inadequate. Much more acceptable would be physicians' voluntary retirement plans as proposed in the Jenkins-Keogh bills now before the Congress. The purpose of these bills is to eliminate the discrimination and inequities which exist under present tax laws by extending the tax deferment privilege to the nation's ten million self employed and also to millions of employees who are not covered by pension plans.

To arrive at the turn of the road in a happy and comfortable frame of mind in 1954 the physician must be cognizant of the fact that the group of those who have reached the Biblical three score and ten, or even higher, is on the increase. Some interest outside of his vocation is a *sine qua non* for happiness. In addition he should be fortified with a pension or retirement program adequate to meet the simple needs of this twilight period of life. Much thought is being given to these problems in Connecticut and the wise physician will not turn a deaf ear.

### Afibrinogenemia

Under Progress in Clinical Medicine in this issue will be found a discussion of one of the most frequent causes of hemorrhage in obstetrical patients, often resulting in maternal deaths. That this condition when recognized at its inception is preventable is now an accepted fact. The Committee on Maternal Mortality and Morbidity of the State Medical Society has been making a study of these cases and is emphasizing the necessity of preparedness by having available a supply of whole blood and of fibrinogen in every hospital where obstetrics is practised.

Too much emphasis cannot be placed on the early recognition of afibrinogenemia and the securing and utilization, in addition to whole blood, of the

proper substance for combatting this condition, namely, fibrinogen available from Red Cross blood banks and from commercial sources. Connecticut may well be proud of its low maternal mortality record but, as in the rest of the nation, there are occurring too many deaths from hemorrhage which are preventable. Hospitals, general practitioners and obstetricians should be alert to the seriousness of afibrinogenemia and should avail themselves of the proper means of therapy.

### Social Security for Connecticut Doctors

The referendum among the members of the Society asking their opinions on OASI coverage for physicians did not produce results that were clearly interpretable although certain implications could be drawn. Whether they will be helpful in expressing the opinion of the medical profession to our representatives in the Congress is open to question.

2,800 questionnaires were distributed and 1,600 were returned which is an unusually high response for a referendum of this kind. Sixteen per cent of those replying stated that they were in favor of social security coverage for physicians and only  $\frac{3}{10}$  of 1 per cent stated that they were not in favor of such coverage. A little less than 1 per cent were exclusively in favor of the optional retirement pension plan as contemplated in the Jenkins-Keogh legislation. The largest proportion, 39 per cent, were in favor of both social security and optional retirement pensions. Somewhat surprising, in comparison to similar surveys that have been made among physicians, is that 21 per cent of those who replied in Connecticut were in favor of neither social security nor retirement pensions.

Analyses of these replies by age group, which is believed to be an important factor in opinion on the subject, was handicapped and not reliable. Such a large number of those who replied omitted to include their age. It is difficult to understand why this was so in a group that is about 98 per cent male and when the reply did not have to be signed.

One point of incidental interest came out was that many members of the Society apparently did not know about the Jenkins-Keogh legislation in spite of the fact that it has been discussed widely in the *Journal of the American Medical Association* and elsewhere.

Conclusions from the survey are rather hard to

come by but it does seem that a large number of Connecticut physicians are interested in social security coverage which does not agree with the stand taken by the House of Delegates of the American Medical Association.

### Spiritual Disease

When a respected individual expresses convictions that are honest, deep rooted and timely his hearers give heed. From Dr. Julian Price of South Carolina recently came this statement: "The most important problem in my opinion, which faces our medical profession today and which offers a challenge to every medical editor . . . (is) what I term spiritual disease."

Shall we not ask searchingly for the reasons for the laxness in our national government in recent years? Or the hold which organized vice has upon legislative and social life, the dishonesty and corruption in various state and local governments? What is at the bottom of the increase in crime in our teen age population, or the evidence of bribery and unethical conduct in amateur athletics? We wonder why so many make an effort to cheat the income tax, and why there is such a mad search for pleasure resulting in an expenditure of four times as much for alcoholic beverages in this nation as for religious and welfare activities. What is the cause of the inroads which the doctrine of atheistic communism is making upon the thinking of some of our citizens?

All these questions and many more are pertinent to this particular malady and, if one reads the daily press, *Collier's*, the *Readers Digest*, and many other lay publications correctly, we as physicians do not seem to be immune. In spite of our Code of Ethics, the Hippocratic Oath, grievance committees, state and county, there are too many in our midst who place private gain above service to their patients, too many who ignore medicine's great tradition of devotion to duty for personal gain. Drastically President McCormick, in his message to the recent session of the AMA House of Delegates, would have the profession cast out from its membership the unethical physician who refuses to place service ahead of financial reward.

Dr. Price, addressing the editors and business managers of state medical journals recently, believes there is only one treatment for this spiritual disease and that must be spiritual. Laws, codes of ethics, grievance committees—none of these will serve to

remove the spirit of greed from the heart of the victim suffering from this malady. There must be a change of heart. To quote Dr. Price, "It is my sincere belief that the greatest need of our country today—and of our profession—is a spiritual rebirth, a return to God and to His eternal principles. And the rebirth must come in the heart of the average citizen and of the average doctor of medicine."

It is a sobering thought that our house is so much in need of cleaning that the newly elected member of the Board of Trustees and the president of the American Medical Association both feel obligated to call upon us to get busy and rid ourselves of the evil within our corporate body. The nation we so proudly claim as ours needs a spiritual housecleaning as never before and the medical profession could profit by the same treatment. Who are better qualified to lead the vanguard of this attack on spiritual disease than each practitioner of medicine in his daily contacts with his patients?

### The Cost of Hospital Care

Elsewhere in this issue will be found excerpts from the "summary" report of the independent, nongovernmental Commission on Financing Hospital Care. Among other phases of the problem discussed in this report is the reason for the present cost of hospital care. The Commission attributes the increases in total hospital operating expenses to inflation, population growth, and increased number of hospital admissions. After adjustments for inflation the Commission found that hospital expenditures rose only 20 per cent in the years from 1935 to 1952.

Compare these findings with the results of the study made by John H. Stewart, assistant business manager of the Hartford Hospital, and published in the January 1954 number of the *JOURNAL*. Mr. Stewart uses the years 1940 to 1952 for his study in which he too points out the influence of inflation on the increase in hospital costs but emphasizes the fact that other factors, viz., improvement in hospital care and increase in payroll, contribute to the present situation. Making an adjustment for inflation also, Mr. Stewart finds the average increase per hospital stay per patient to be about 37 per cent. If one relates this item to the annual per capita income in Connecticut for each of these two years, 1940 and 1952, there is only a fraction of one per cent increase.

There are two other phases of financing hospital



care considered by the Commission. One is voluntary prepayment and here the Commission recognizes and points out the great need for eliminating unnecessary hospital admissions if prepayment costs are to be kept low enough to cover the group which most needs this method of financing. The Commission also points out certain improved methods of financing hospital care for groups unable to afford prepayment or unable to meet the costs of hospital care in other ways. Included in these groups are people on public aid, the aged, the unemployed, the disabled, and those of low income.

There is much of interest in the Commission's report. Physicians, patients and hospital administrators, as well as the great public at large which must support as well as find personal use for our hospitals, must give serious thought to the changing pattern of financing hospital care.

### Regular Medicine and the Cults

Using the word regular to describe physicians of the old school is no novelty and the writer knows of no better word for this purpose. For hundreds of years the methods used by regular physicians in treating sick people have been limited only by their consciences; in a word they may use any treatment which in their belief is likely to benefit a patient. Cultists on the other hand are limited in their treatment by certain theories such as the "Similia Similibus Curantur" and the tremendous dilutions of drugs formerly prescribed by homeopaths under the tenets of Hahneman. The writer cannot see how any healer who publicly labels himself as a believer in a cult can avoid being classed as a cultist.

The history of the relation of the regular profession to cults is an interesting one from several points of view. At the time when Hippocrates flourished physicians were forbidden the "cut for the stone," but this negation, incorporated in the Hippocratic Oath, has been removed by medical schools and there are several such which require their students to affirm their adherence to the oath.

In spite of the enormous strides which medicine has made in the past seventy-five years, particularly in the prevention of certain infectious diseases and the discovery of new drugs, it still tends to go in cycles. This must be confusing to the layman and

even the doctors themselves. Much has been done in recent years to educate laymen in medical matters but it has not always been wisely done, and the opinions of some so-called experts must have led at times to confusion rather than enlightenment. As Francis Galton, once a medical student, observed years ago, many doctors tend to be much too positive in their statements regarding disease and some medical contributors to large magazines have been more interested in the spectacular than in the scientifically proven.

The story of the cults in their relation to regular medicine is a matter of history. Some cults have died of inanition, but many of them have in time become absorbed into regular medicine and have disappeared, regular physicians taking over what was good in them.

While osteopathic medical schools have doubtless improved greatly since the advent of the cult, it is a matter of personal opinion whether it is wise to recognize what is obviously a cult as technically not a cult. Certainly everything possible should be done to encourage improvement in the teaching in osteopathic schools. As to the graduates of regular medical schools teaching in osteopathic schools, the writer happens to know that this has been going on for a good many years as one of his former students became, after graduation from a regular school, professor of anatomy in an osteopathic school. There are doubtless other practitioners who possess degrees from both types of school. How long it will take for osteopathy to be completely absorbed into regular medicine no one can predict, but in the light of past experience it will probably occur in time.

G. B.

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### The American Journal of Gastroenterology

The National Gastroenterological Association announces that the name of its official publication, established in 1934, has been changed from *The Review of Gastroenterology* to *The American Journal of Gastroenterology* effective with the January 1954 issue. The publication will continue to be edited by Dr. Samuel Weiss, editor-in-chief, and an Editorial Board consisting of Drs. Milton J. Matzner, James T. Nix and Michael W. Shutkin.

## PROGRESS IN CLINICAL MEDICINE

### AFIBRINOGENEMIA: A REVIEW

CHARLES H. PECKHAM, M.D., *Manchester*

#### HISTORICAL BACKGROUND

THE past twenty-five years has seen a great decrease in maternal mortality throughout the entire world. Nowhere has this decrease been more significant than in this country. Thus, in 1928, the statement could be made that, with the exception of Chile in South America, maternal mortality was higher in the United States than in any of the so-called civilized countries of the world. Now deaths associated with childbearing are only a small fraction of their former figure and mortality rates here are lower than those reported by other nations.

In 1928 the great majority of maternal deaths were due to one of the following three causes, listed here in order of frequency: infection, toxemia, and hemorrhage. Now the same "big three" prevail but the first and third have changed positions in the frequency scale. The greatest improvement has, of course, taken place in the infection group, both puerperal and postabortal. This has been due in part to a policy of less meddlesome obstetrics, but mainly to the use in earlier years of the sulphonamides and more recently to the various antibiotic medications. Toxemic deaths decreased years ago as accouchement force fell into disfavor, and more recently as prenatal care has become the rule rather than the exception and the prophylaxis of the toxemic condition has become better understood. The death rate from hemorrhage has fallen in direct proportion to the speed and adequacy with which blood loss may now be replaced in cases associated with uterine bleeding. In fact, it is now a rare hospital which accepts obstetrical patients and does not possess a blood bank.

From the above it becomes obvious that, although obstetric mortality has lessened in all causative categories, the amount of decrease has been least in the

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The Author. *Obstetrician and Gynecologist, Manchester Memorial Hospital, Manchester, Connecticut*

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#### SUMMARY

With the drop in maternal mortality during the past 25 years there has not been a corresponding drop in the group of cases due to hemorrhage, but only in the infection and toxemia groups. At the present time the major portion of maternal deaths are due to hemorrhage. Almost all of this group in which the hemorrhage is due to a decreased clotting ability are preventable. The deficiency in clotting is due to an extreme lowering of fibrogen, which is usually associated to a lesser degree with a decrease in prothrombin and occasionally in the presence of a circulating fibrinolysin. The condition has been termed "afibrinogenemia" and is found in some cases of severe premature separation of the placenta, in cases of fetal death in utero with prolonged retention of the products of conception, and in certain instances of amniotic fluid embolism or infusion when death does not occur almost immediately. Diagnosis of the condition clinically may be made very simply by the "clot observation test." Treatment of afibrinogenemia from whatever cause should include prompt blood replacement by transfusion together with the intravenous use of sufficient fibrinogen to cause a stable clot. Fibrinogen has been obtainable in a limited amount from the Red Cross and from Dr. Reid and his staff in Boston. A limited amount of the product is now available commercially.

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hemorrhage group so that at the present time more deaths occur due to hemorrhage than to any other single cause. Accordingly the investigation, prophyl-

*From the Department of Obstetrics, Manchester Memorial Hospital*



laxis, diagnosis and treatment of those conditions associated with bleeding has become a matter of paramount importance to every obstetrician. Within the past few years it has been realized that an important group of these conditions whose chief physical sign is hemorrhage are associated with a decreased clotting ability of the blood, and that with proper treatment almost all of the deaths occurring with these complications are preventable. It will be the purpose of the following paragraphs to consider each of this group of conditions from the standpoint of clinical course, pathology, and treatment.

That certain instances of uterine hemorrhage were associated with a deficiency in the clotting of the blood was apparently noted for the first time by DeLee of Chicago, who in 1901 published an article entitled "A Case of Fatal Hemorrhagic Diathesis with Premature Detachment of the Placenta." Actually the author discusses three cases, of which two are convincing. One may have been an instance of bleeding associated with an inevitable or incomplete abortion. A second case, however, details collapse and postpartum bleeding associated with a "hard uterus" following the delivery of a six months syphilitic macerated fetus. The third case is classical and relates the history of a 35 year old multigravida who developed a typical severe premature separation of the placenta without going into labor. An attempt to induce labor by the insertion of an intrauterine bag failed. Since the patient's condition was poor, an infusion of saline solution was started which resulted in "deep blue ecchymoses appearing around the puncture and extending up into the axilla, blood oozing persistently from the hole and not to be stopped with plaster." Following attempts at manual dilatation of the cervix lasting two to three hours, craniotomy failed to produce delivery which was, however, finally effected by podalic version and extraction. Despite the fact that the uterus contracted well, bleeding continued, even after the insertion of a tight pack. Eventually the patient died with bleeding still going on from the uterus, infusion sites and needle punctures. DeLee thought that this patient had developed a temporary hemophilia and finally states: "Three cases, occurring in three years, have forced on the writer the belief that there are alterations of the blood or blood vessels, of a temporary nature, which prevent its clotting, and thus, during labor or operations, cause death." A few years after DeLee's initial observation Williams reported a

case of premature separation of the placenta with bleeding for 12 hours after delivery. A series of cases of this type was published later by Davis and McGee. In 1922 Willson reported similar findings and suggested cesarean section with hysterectomy in severe cases of uteroplacental apoplexy. A most important contribution to the subject was made by Dieckmann in 1936 who studied the blood fibrin in grams per cent in eleven cases and obtained readings below normal in all and in eight found the level significantly low. It was the author's feeling that the prolonged bleeding in some of his cases was probably due to an extreme decrease in blood fibrinogen from blood loss, mobilization of fibrinogen at the site of hemorrhage, or liver damage. In one of Dieckmann's cases bleeding was noted not only from the uterus but from the gums, stomach, and subcutaneous tissue.

The above brief historical resumé indicates that by 1936 the profession was aware that profuse and often fatal hemorrhage occurred from time to time in severe instances of premature separation of the placenta, that such hemorrhage was associated with a deficiency of the clotting ability of the blood, and that such a deficiency was probably due a decrease in or absence of fibrinogen.

The past five years has witnessed a great increase in our knowledge of the subject and here we owe our information primarily to the important contributions of Reid and his associates in Boston, to whose work reference repeatedly will be made. It has been found that a deficiency in blood fibrinogen, or "afibrinogenemia" as the condition is commonly termed, occurs not only with premature separation of the placenta but in certain instances of fetal death in utero with prolonged retention of the embryo and in the occasional case of so-called amniotic fluid embolism or infusion where death does not supervene almost immediately. Finally, it has been learned that almost all of the above conditions may be treated successfully by prompt replacement of blood loss by transfusion together with the intravenous use of fibrinogen in the form of Cohn's Fraction I.

#### THE BLOOD CLOTTING MECHANISM

Before entering upon a discussion of afibrinogenemia and its effect it is well to understand the clotting ability of the blood in normal pregnancy. Various investigators are in agreement that normally

during pregnancy the blood fibrinogen concentration increases and averages 325 mg. per cent. The prothrombin activity is also elevated and averages 130 per cent of normal. The clotting mechanism itself is unaltered. With threatened or inevitable abortion the clotting mechanism is unchanged, although in certain cases of missed abortion there is a tendency for the patient to bleed excessively during labor due presumably to the presence of a weak circulating fibrinolysin. No clotting abnormality has been noted in cases of hydatidiform mole, postpartum hemorrhage due to atony, placenta praevia, or in the milder cases of premature separation. With the various types of toxemia of pregnancy coagulation is normal since the presence of a weak circulating fibrinolysin is apparently more than compensated for by an actual increase in blood fibrinogen to 450 mg. per cent or higher.

In only three groups of cases then has there been observed an upset coagulation mechanism associated with afibrinogenemia and hypoprothrombinemia. To repeat, these are: (1) severe premature separation of the placenta, (2) fetal death in utero with prolonged retention of the embryo, and (3) amniotic fluid embolism. Accurate diagnosis of the condition obviously depends on chemical assay of the blood fibrinogen and prothrombin, although these are highly technical and protracted procedures. Fortunately from a clinical standpoint diagnosis may be made in a brief and simple manner. Five cc. of venous blood is drawn, placed in a clean, dry test tube and either incubated for one-half hour at 37° C or kept at room temperature. If a stable clot is present at the end of this time blood fibrinogen is adequate. If a clot forms but fails to remain stable the level of fibrinogen has probably fallen below 100 mg. per cent (although occasionally this phenomenon is observed with a level up to 150 mg. per cent). It should be stated that an unstable clot may also be an indication of the presence of a fibrinolysin. Initial failure of clotting is indicative of a severe afibrinogenemia. Both failure of clotting and clot instability may be present with only a slight fall in prothrombin readings. From a clinical standpoint the presence of anything but a completely stable clot is significant and indicates prompt treatment.

#### PREMATURE SEPARATION OF THE PLACENTA

Some degree of premature separation of the normally implanted placenta is a reasonably common complication of late pregnancy and labor, the

reported incidence varying between one in 85 deliveries and one in 250. The vast majority of cases are mild and have no serious effect on either the mother or her child. Indeed, the diagnosis is frequently made subsequent to delivery only when old clotted blood is passed and inspection of the placenta shows a relatively small flattened area which may or may not have a clot attached to it.

The average case is somewhat more severe. Moderate vaginal bleeding is noticed and usually a relatively small area of the uterus is tender to palpation. The patient often complains of pain in the tender area. The blood pressure may be elevated and a small amount of albumin may be present in the urine. The condition of the patient remains good, blood loss is not great and the patient shows no evidence of shock. Usually there is no sign of fetal distress in this group and if so it is not an early phenomenon. The clotting power of the blood is undisturbed and blood fibrinogen remains within normal limits.

In about five to ten per cent of instances of premature separation the condition is very severe and usually becomes so at an early stage. Hemorrhage is usually profuse, although frequently much of it may be concealed. There is severe pain over the uterus which is extremely hypertonic and does not relax. Shock is frequently noted and is often out of proportion to the actual blood loss. The fetal heart is absent. It is in this group of cases that the blood fails to clot or the clot, once formed, proves to be unstable and on examination a marked afibrinogenemia is found.

The method of production of the afibrinogenemia in severe cases of premature separation remains unsolved. It seems probable that the phenomenon is due to the entrance into the maternal circulation of some substance capable of defibrinating blood. It is the opinion of Reid and most other investigators that the offending substance is thromboplastin. The actual course of events would seem to occur as follows. The thromboplastic material is derived presumably from the damaged decidua and placenta. As the area of separation grows an increasing retroplacental clot is formed. Consequently intrauterine pressure becomes considerably elevated. When this pressure reaches a point where it exceeds the pressure in the venous channels at the site of placental separation, the thromboplastin containing materials are forced into the maternal blood spaces. This material causes extensive intravascular clotting which im-



mobilizes the available fibrinogen, thus causing the development of afibrinogenemia in the circulating blood. It seems likely that in some instances at least the presence of a circulating fibrinolysin may contribute materially to the picture.

There is no unanimity of opinion so far as treatment of premature separation of the placenta is concerned, the policy in various clinics ranging from induction of labor to the routine employment of immediate cesarean section. As is generally the case when such extremes are noted a middle-of-the-road policy probably gives the best results statistically. Some of the mildest cases will need no treatment at all since the bleeding will subside, the entire process quiet down, the pregnancy continue, and the patient deliver normally at term with evidences of a mild separation noted on inspection of the placenta at the end of labor. Patients with a moderate degree of separation may frequently be delivered normally following induction of labor by rupture of the membranes. Here pitocin may speed the onset of labor, provided it be used intranasally first to detect the occasional individual hypersensitive to the drug, and later intramuscularly starting in doses of one minim and increasing cautiously to three minims. It must be emphasized that the pitocin should be used to induce labor but never to hasten it, once the uterine musculature is contracting normally. The cautious use of pitocin as in intravenous infusion by slow drip is also of aid in causing the establishment of labor in refractory individuals. At the time the sterile pelvic examination is done for rupture of the membranes the operating room should be in readiness for laparotomy, since occasionally the condition which has simulated a premature separation will be found on examination to be a partial or even total placenta praevia. Also on admission and before any manipulation is done the patient should be grouped, matched for transfusion, and two pints of blood held in readiness for transfusion until some time after delivery is effected. It is generally felt that in this type of case cesarean section is occasionally indicated, but its use is probably limited to those instances where the fetal heart becomes irregular and the likelihood of early delivery is scant. In other words the indication for section in this group is fetal rather than maternal.

All of the maternal deaths due to premature separation occur in the five to ten per cent comprising the very severe cases. These cases may or

may not show evidence of an accompanying toxemia but this added complication will rarely influence treatment. Here hemorrhage is profuse and shock often out of proportion to the hemorrhage. As soon as such a patient is admitted blood should be obtained and transfusion begun. The amount of replacement will be in direct proportion to the estimated blood loss. Also a tube full of blood should be set aside to determine whether or not afibrinogenemia is present for it is in this group of patients alone that the condition occurs. If the blood clots and the clot remains stable, no fibrinogen replacement is necessary but the procedure should be repeated hourly until after delivery, since experience has shown that afibrinogenemia may develop rapidly at any time. If the clot is stable an attempt should be made to rupture the membranes, whether or not the cervix is favorable for the induction of labor. Rupture of the membranes is often followed quickly by the onset of labor in this type of patient, even though the cervical canal is long and fairly rigid. In addition this procedure lowers intrauterine pressure and probably slows up the advance of the separation as well as decelerating the rate of fibrinogen immobilization.

If at the time of admission the blood fails to clot or the clot proves unstable, the immediate replacement of fibrinogen intravenously is imperative. There are no set rules for the amount to be used but a fair clinical rule would be the use of 1 Gm. of fibrinogen for each 500 cc. of blood lost and hence to be replaced. Thus 1000 cc. of blood transfused would be accompanied by 2 Gms. of fibrinogen intravenously. It is important that fibrinogen should be infused until a stable blood clot is produced. Once this has occurred the membranes should be ruptured artificially as indicated above. More blood should be available and more fibrinogen ready in case of need. If after a few hours of ruptured membranes the patient fails to go into labor, delivery should be effected by cesarean section, making sure in advance of any operative procedure that a stable clot is present. It should be emphasized that, although fibrinogen replacement has been adequate once, it may fall suddenly again at any time until after delivery. Cesarean section should never be done in the presence of afibrinogenemia. It is the author's opinion that cesarean section with hysterectomy is rarely if ever indicated with this method of therapy.

## FETAL DEATH IN UTERO

In 1950, during the course of their investigation into the clotting mechanism of the blood in normal and abnormal pregnancy, Reid and his co-workers reported the case histories of three patients who had dead babies in utero and bled profusely just before, during, or just after labor. In each of these cases the blood picture was exactly like that described above under premature separation and was typical of afibrinogenemia. However, in not one of these cases was there the slightest evidence of premature separation. In other words here was typical afibrinogenemia with an intact placenta. Since then other such cases have been reported and in a recent article Reid added six more to his series. Frequently Rh isoimmunization in utero was the cause of fetal death but since it was not always present it was obviously not the cause of the clotting defect itself. The only unusual finding was prolonged retention of the embryo in utero after death, the duration of retention in Reid's cases varying between five and eleven weeks prior to the onset of bleeding. Fetal death had occurred at various stages of gestation and in one case the embryo weighed only six ounces when expelled. The actual bleeding with afibrinogenemia manifested itself sometimes before the onset of labor, in fact in one instance the patient failed to go into labor after having been observed with afibrinogenemia for two weeks. In other cases the bleeding was noticed first during parturition or immediately after expulsion of the uterine contents. In the last group the uterus remained well contracted but bleeding continued. A notable feature of this type of case was the frequency with which the initial bleeding came from the mucous membrane of the respiratory or gastrointestinal tract or from areas of ecchymosis and only later was there hemorrhage from the uterus itself.

Examination of the blood in these cases revealed afibrinogenemia in various degrees, some reduction in prothrombin time although not to a hemorrhagic level, and no evidence of a circulating fibrinolysin. Clinical diagnosis could be made by observation of clotting and clot stability as in patients with premature separation of the placenta.

The mechanism of production of afibrinogenemia here is believed to be similar to that in the group of cases previously described: namely, that a coagulant, probably thromboplastin, gains access to the maternal circulation and causes extreme intravascular coagulation resulting in fibrinogen depletion. It is

here postulated that placental autolysis slowly occurs following fetal death in utero, that the thromboplastin is derived from this tissue and that, with devitalized tissue in contact with the maternal blood spaces, the coagulant is transferred by Braxton-Hicks contractions or the actual forces of labor.

In view of the above statements it becomes obvious that close watch must be kept upon any patient whose embryo dies in utero and is not expelled within a very few days. Blood should probably be obtained at least twice a week and the clot observed for stability. If at any time the patient bleeds or if an unstable clot is obtained, the patient should be hospitalized until after delivery. It would seem that in most cases labor will set in shortly after the onset of bleeding if it has not already preceded it. Here prompt blood replacement with the addition of fibrinogen intravenously as outlined under treatment with premature separation of the placenta will carry the patient along until she is delivered. Once delivery has been effected and a stable clot is present, the emergency is over.

This leaves as a major problem the occasional patient where bleeding begins, afibrinogenemia is present, and the patient fails to go into labor. Here fibrinogen should be given until the blood is stabilized and the patient followed in the hospital. Ordinary methods of induction of labor are not only useless but also hazardous in this type of case. It is to be hoped, of course, that labor will set in within a relatively short time—and it usually does. In the rare instance where labor fails to eventuate, in order to solve the problem with minimal risk of infection Reid advises hysterectomy on the unopened uterus. This may seem like a radical procedure but actually is not when the risks of other types of therapy are carefully evaluated. Obviously such an operation should only be undertaken after the administration of enough fibrinogen to insure normal clotting of the blood.

## AMNIOTIC FLUID INFUSION

In 1941 Steiner and Lushbaugh reported the case histories of eight patients who had suddenly gone into a state of profound shock during labor and had died, either undelivered or within a few hours after delivery. Since on autopsy the chief finding was a "widespread embolism of the small pulmonary arteries, arterioles and capillaries by the particulate matter found in amniotic fluid and meconium," the condition was termed amniotic fluid embolism.



The authors further stated that the disease could be duplicated clinically and pathologically in rabbits and dogs by the intravenous injection of human amniotic fluid and meconium.

Since the above date the findings of Steiner and Lushbaugh have been confirmed and their studies extended. It has been found that the condition is observed most frequently in multiparae of the older age group who are often past term and have big babies. It occurs most frequently near the end of the first stage of labor when the uterine contractions are hard and violent and often when labor has been stimulated by oxytocics. Symptoms of shock, drop in blood pressure, restlessness, dyspnoea and cyanosis rapidly develop and death frequently occurs in a matter of minutes. If the patient survives the initial shock, death often occurs a few hours after delivery from postpartum hemorrhage. In these cases of delayed death bleeding was observed from mucous membrane and organ surfaces as well as from the uterus.

Recent studies by Reid and his co-workers have resulted in evidence that the situation here is similar to that found in severe cases of premature separation and in labor following prolonged retention of a dead fetus in utero. It would seem that violent uterine contractions, particularly after rupture of the membranes and when the birth canal is filled by a large baby, are capable of raising intrauterine pressure to a point where amniotic fluid and meconium are forced into maternal blood vessels and particularly into the endocervical veins. In that way the amniotic fluid gains access to the maternal circulation. This material by itself probably does not cause death, for frequently at autopsy the pulmonary findings as detailed by Steiner and Lushbaugh are minimal. However, the material does contain a large amount of thromboplastin which attracts fibrinogen and causes extensive intravascular clotting. If a large amount of this thromboplastic material gains access to the maternal circulation over a short period of time, death rapidly comes. If a smaller amount enters over a longer period of time, defibrination of the blood occurs with hemorrhage from afibrinogenemia resulting. Reid has suggested the term amniotic fluid infusion rather than embolism as being more accurate for this condition.

Obviously the treatment of those cases of massive amniotic fluid infusion with rapid death can only be prophylactic at the present time. Here particular

caution should be expressed concerning the use of pitocin and similar substances to speed up a normally proceeding labor. Also it seems wise to apply the first pitocin, if used, by the intranasal route in order to avoid the untoward reaction from the drug in the occasional individual who is hypersensitive to it. If the patient survives the initial shock or if the condition is less severe from onset, clot observation tests should be done to detect the development of afibrinogenemia; and should the condition appear and hemorrhage occur, prompt blood replacement with the use of sufficient fibrinogen intravenously to produce a stable clot may well prove to be life saving therapy. Reid recommends that an initial 4 Gms. of fibrinogen be administered and a further amount promptly given if the first injection does not produce a stable clot.

#### AVAILABILITY OF FIBRINOGEN

Up to the present time the amount of fibrinogen available has been small and has been produced by the American Red Cross as well as one of the commercial companies for experimental use only. Connecticut has been fortunate in obtaining a limited amount of Red Cross fibrinogen through the generosity of Reid and his co-workers and recently through the second source. A limited amount of fibrinogen in 1 Gm. containers is now available commercially. This fibrinogen is marketed under the trade name of Parenogen by the Cutter Laboratories. It is the feeling of the author that every hospital accepting obstetrical patients should possess a minimum of 10 units of this substance to care for any emergency. At the present time, due to limited supplies, a maximum of six units only is available to each hospital. It is suggested that an additional supply be concentrated in a central depot so that any institution needing more than is locally available be promptly supplied in this fashion.

It should be emphasized that whenever any blood fraction, including fibrinogen, is administered the danger of the subsequent development of homologous serum jaundice must be considered. Fibrinogen available at present has been sterilized with ultraviolet rays. However, afibrinogenemia is such a serious condition with so high a mortality when replacement therapy is not used that it is felt that the fear of homologous serum jaundice should not prohibit the use of the fibrinogen preparations now available.

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### Dr. Buxton Appointed

Dr. Charles Lee Buxton, a member of the faculty of Columbia University College of Physicians and Surgeons, has been appointed Professor of Obstetrics and Gynecology and Chairman of the Department effective April 1954. He will succeed Dr. Herbert Thoms who has retired after serving as chairman of this department since 1947.

Dr. Buxton, who was born in Superior, Wisconsin, received his B.S. degree from Princeton University in 1927 and his M.D. from Columbia University in 1932. In 1940 he received the Doctor of Medical Science degree from Columbia. Following his graduation from medical school, he interned in surgery at the Mary Imogene Bassett Hospital in Coopers-town, New York. The internship was followed by a year as a research fellow in anatomy at Harvard. From 1934 to 1938, he served on the house staff of Sloane Hospital for Women in New York City.



*Alburtus-Yale News Bureau*

DR. C. LEE BUXTON

In 1938 he was appointed an assistant attending in obstetrics and gynecology at Sloane Hospital and an assistant in obstetrics and gynecology at Columbia University College of Physicians and Surgeons. During World War II he served in the U. S. Navy Medical Corps at Annapolis and later in the Pacific Theater and was released from service with the rank of commander. He became an associate attending and chief of clinic at Sloane Hospital and an associate professor at Columbia in 1947. Since 1951 Dr. Buxton has been Professor of Clinical Obstetrics and Gynecology at Columbia.

His publications and research activities reveal Dr. Buxton's wide interests in the various aspects of obstetrics and gynecology; however, he has been particularly interested in the problems of sterility and gynecological endocrinology. He has served since 1948 as a member of the editorial board of the *Journal of Clinical Endocrinology and Metabolism*.

In addition to his appointment as Professor and Chairman of the Department, Dr. Buxton will be Obstetrician- and Gynecologist-in-Chief of the Grace-New Haven Community Hospital University Service.



## THE PRESIDENT'S PAGE

### SOCIALISTIC TRENDS IN MEDICINE

*"All that is necessary for the triumph of  
evil is that good men do nothing."*

*Edmund Burke*

TEN years ago the medical profession united to meet the emergency of the proposed Murray-Wagner-Dingell socialized medicine bill. At the present session of the 83rd Congress more socialistic measures than ever before will be given prominence as "must legislation."

Every doctor should be well informed regarding these avenues of approach to socialism and should do everything within his power to combat the dangers that face us.

Hearings on health legislation are now being held. The Ives bill, S1153, proposes to subsidize the voluntary plans, Public Health units, medical and nursing schools, and other health facilities. President Eisenhower's medical and health program does not go as far as the Ives Bill but calls for the reinsurance of the various health plans through a government reinsurance corporation. This means the intrusion of the federal government into our system of free enterprise, individual initiative and responsibility. If the government goes into the reinsurance business either it will be self supporting from fees, which is no advantage over the private reinsurance plans already operating, or else it will not be self sustaining and there you have a government subsidy for health insurance all ready to be expanded into a full-scale, national, compulsory scheme.

Another precarious avenue to socialized medicine is the ever increasing Veterans Administration medical care program. There are 20,000,000 veterans in the United States with a yearly increase of 800,000. If the federal government continues to provide benefits to this group for nonservice-connected disabilities, then this expanded program of free medical care and hospitalization will be furnished by the government for approximately one-third of the adult citizens of this country.

Furthermore, a bill has been prepared for Congress to furnish medical care to the dependents of military personnel. This would mean that drafted doctors would have their services given away for the care of these dependents.

The extension of Social Security to 10,000,000 more persons with the inclusion of doctors is already under way. Organized medicine is opposed to this expansion of Social Security on the basis that it is actuarially unsound, tax eating, and another step towards state socialism.

The American medical profession faces a difficult and critical year. Doctors must be prepared in the coming months to make real sacrifices of effort, time, and money in a stand against the socialistic trends in medicine.

George H. Gildersleeve, M.D.

# THE SECRETARY'S OFFICE

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## CALL

### ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1954 Annual Meeting of the House of Delegates will be held in the auditorium of the Bulkeley High School, Hartford, (use Maple Avenue entrance) commencing at 10:00 o'clock in the morning of Tuesday, April 27.

Following luncheon, the House will reconvene for the completion of business.

George A. Gildersleeve, President  
Creighton Barker, Secretary

#### INTRODUCTION OF RESOLUTIONS BY-LAWS ARTICLE VII, SECTION 4

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

### Council Meeting

The February meeting of the Council was held at the offices of the Society on February 11, 1954. The meeting was called to order by the Chairman at 4:30 P. M. There were present in addition to the Chairman, Dr. Danaher, Drs. Gildersleeve, Marvin, Barker, Weld, Whalen, Fincke, Ogden Alternate for Gallivan, Walker, Tracy, Gettings, Labensky. Speaker of the House Dr. Gibson, Vice-Speaker Dr. Feeney, Alternate Councilor Dr. Buckley. Ab-

sent: Drs. Couch, Murdock, Gallivan, Flaherty, Ottenheimer, Gens, Ursone, Otis, Archambault and Gilman.

#### NOMINATIONS 1954-1955

The Nominating Committee held its second meeting at 4:00 this day, just preceding the meeting of the Council and completed nominations of officers and committees for the year 1954-1955, except nominations for the Editorial Board of the JOURNAL, which it is proposed to change by an amendment to



the By-laws to be passed upon at the Annual Meeting of the House of Delegates, April 27, 1954. The nominations made by the Nominating Committee were reviewed by the Council and they were approved without change for presentation to the House of Delegates at the Annual Meeting. (AMB 2-11-54-"A")

#### BY-LAW AMENDMENT; OPERATION OF THE JOURNAL

Dr. Marvin presented a report for the Subcommittee to Study JOURNAL Operations. (AMB 2-11-54-"B") Mainly this report consisted of the following recommendation for the amendment of the By-laws of the Society.

Article VI, Sec. 1, Par. 1—The designation of "Editor-in-Chief of the JOURNAL" shall be changed to "*Managing Editor of the JOURNAL*."

Article VI, Sec. 1, Par. 1—delete "the Literary Editor of the JOURNAL." (This removes the Literary Editor as an officer of the Society.)

Article VI, Sec. 2, Par. 6—The designation of "Editor-in-Chief of the JOURNAL" shall be changed to "*Managing Editor of the JOURNAL*."

Article VI, Sec. 2, Par. 7—should be deleted in its entirety. (This paragraph states the duties of the Literary Editor.)

Article VI, Sec. 2, Par. 8 becomes Par. 7. Par. 9 becomes Par. 8. Par. 10 becomes Par. 9.

Article VI, Sec. 2, Par. 10—The designation of "Editor-in-Chief of the JOURNAL" shall be changed to "*Managing Editor of the JOURNAL*."

Article IX, Sec. 1, Par.—The designation of "Editor-in-Chief of the JOURNAL" shall be changed to "*Managing Editor of the JOURNAL*."

Article IX, Sec. 1, Par. 1—delete, "the Literary Editor of the JOURNAL." (This removes the Literary Editor of the JOURNAL as a member of the Council.)

Article IX, Sec. 2, Par. 2—delete, "except the Literary Editor of the JOURNAL who shall not vote." (This refers to the privileges of the Literary Editor as a member of the Council.)

Article X, Sec. 3, Par. 3, to be amended to read as follows: The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the

Editorial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board shall be selected so far as feasible, to represent the major division of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the state. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

It was voted to accept the report as presented by Dr. Marvin and recommend the proposed amendment to the By-laws to the House of Delegates at the Annual Meeting on April 27. Included in the motion was a directive to the executive secretary to make such editorial changes in the proposed motion as would be required for consistency with existing provisions, of the By-laws and to propose amendments to other By-laws that may be incompatible with this change. To that end further amendments to the By-laws are necessary.

#### ALTERNATE COUNCILORS

Dr. Whalen, Chairman of the Subcommittee on the Status of Alternate Councilors discussed the report of that committee which had been distributed to the members of the Council prior to this meeting. (AMB 2-11-54-"C") It was voted to approve the following recommendations contained in the report (1) the Council through the simple adoption of "floor rules," acknowledge the Alternate Councilors, Speaker and Vice-Speaker of the House as "associate members" of the Council for the time being with all privileges except those of making motions and voting and (2) that the Chairman of the Council, the President of the Society, and the executive secretary in conference shall make nominations to the Council at its next meeting for a committee to prepare revision of the Charter and By-laws of the Society for presentation to the House of Delegates in December, 1954 with the intent to have such

Charter changes as are made submitted to the General Assembly of the State of Connecticut during its 1955 Session. The number of members to serve on this committee is to be determined by the Chairman of the Council, the President of the Society, and the executive secretary.

COMMITTEE ON NATIONAL LEGISLATION

The secretary proposed that additional funds be allotted to the Committee on National Legislation for the year 1954 explaining, that the Committee had already overspent its 1954 budget allotment due to the expense of distributing AMA literature in support of the Bricker Amendment to the Constitution of the United States, and a referendum to all members of the Society on Social Security coverage for physicians and the voluntary pension proposals in the Jenkins-Keogh bill. It was voted that an additional allotment of \$150 be made to the Committee on National Legislation and to inform the Chairman of the Committee that the Council requests that it seek from the Council more guidance as to policy and that the Committee report frequently to the Council concerning its past and proposed activities.

PROFESSIONAL POLICY COMMITTEE, HARTFORD  
COUNTY RESOLUTION

A resolution passed by the Board of Directors of the Hartford County Medical Association at its January meeting was presented. The resolution follows (AMB 2-11-54-“D”).

“The Board of Directors of Hartford County Medical Association recommend to the state Council that more adequate proportional representation of medical men on the board of directors of the Professional Policy Committee of CMS be achieved.”

Dr. Ogden explained that the expression “medical men” referred to physicians in medical practice rather than those engaged in surgery and allied fields. Dr. Feeney, Chairman of the Board of Directors of the Hartford County Medical Association was asked to enter the discussion as did many others. Dr. Danaher explained the present make-up of the Professional Policy Committee and the several fields of medical practice represented by members of the Committee and the Board of Directors of CMS. It was finally voted that the Chairman of the Council appoint a special subcommittee of three members of the Council to study the proposals of the Hartford County Medical Association and report to the Council at its next meeting.

PROFESSIONAL LIABILITY INSURANCE PROBLEMS

The executive secretary, in accordance with instructions by the Council at its January meeting, reported that a pamphlet on professional liability insurance problems was available from the Council on Medical Service of the American Medical Association. It was voted that a supply of these pamphlets be obtained and a copy be sent to each new member of the Society at the time of his election. It was also noted that members of the Council desired to have copies of this pamphlet.

“GHOST” SURGERY

Dr. Labensky discussed the hazard of permitting interns and residents to do surgery and have the attending surgeon collect insurance fees for such services and read at length an article from the *New York World Telegram*, February 10, 1954. (AMB 2-11-54-“G”).

MARCH MEETING

It was agreed that the next meeting of the Council be held at the offices of the Society on Thursday, March 11. The meeting adjourned at 6:45 P. M.

Delegates to Annual Meeting

The By-Laws of the Society provide that each county association is entitled to one delegate in the House of Delegates for each thirty-five members in the association or fraction thereof based on the membership as of December 31 of each year. According to this, the quota of delegates from each county association who should attend the Annual Meeting of the House of Delegates which will be held in Hartford, April 27 and the Semi-Annual Meeting in December is as follows:

COUNTY	MEMBERSHIP	OFFICIAL
	DECEMBER 31, 1953	DELEGATES
Fairfield .....	739	22
Hartford .....	871	25
Litchfield .....	122	4
Middlesex .....	94	3
New Haven .....	802	23
New London .....	159	5
Tolland .....	15	1
Windham .....	61	2

The secretary's office will appreciate being informed as soon as possible, the names and addresses of all of the delegates who will represent your county at the Annual Meeting of the House of Delegates in Hartford. The agenda for the meeting is now being prepared and will be delivered to each delegate as soon as possible. If any of the delegates



from a county association cannot attend the meeting, this office should be notified who their alternates are to be and these alternates will be supplied with the agenda and reports.

### Election of Councilors

Councilors should be elected for a term of two years at the annual meeting of the county associations this year in Fairfield, Litchfield, New Haven and Tolland counties.

### Appointment to Committee on Professional Relations

The By-Laws require that the county associations in Fairfield, Litchfield, New Haven and Tolland counties at their annual meeting in 1954, elect a past-president of the association to serve for two years on the state Committee on Professional Relations. No member of the Council of the State Medical Society is eligible for election to this committee and no member shall be elected to serve two consecutive terms.

### Meetings Held in February

- February 1—Conference Committee With the Connecticut Pharmaceutical Association
- 1954 Clinical Congress Committee
- February 2—Connecticut Nutrition Council
- February 3—Medical Examining Board
- February 4—Committee on Public Health
- February 11—Nominating Committee
- Monthly meeting of the Council
- February 15—Arrangement Committee for 1954 Annual Meeting
- State Advisory Council for Connecticut Hospital and Public Health Center Construction Program
- February 16—Board of Directors—Connecticut Medical Service
- February 17—Committee on Maternal Mortality and Morbidity
- February 18—Committee on School Health
- February 24—Committee on Neonatal Mortality
- Medical Examining Board
- February 25—Committee on the Improvement Care of the Patient

### New Members

(Elected January 26, 1954)

#### LITCHFIELD COUNTY

John B. Irwin, Torrington  
Howard S. Jeck, Jr., Torrington

### Medical Center Established by Yale School of Medicine and Grace-New Haven Community Hospital

The Yale University School of Medicine and Grace-New Haven Community Hospital will expand their affiliated activities under a new program to be known as the Yale-New Haven Medical Center. Hiram Sibley, executive director of the Connecticut Hospital Association since 1948, has accepted appointment as Director of Program Development for the new medical center and nine leaders of the hospital and medical school have been appointed to an Advisory Committee to further the program.

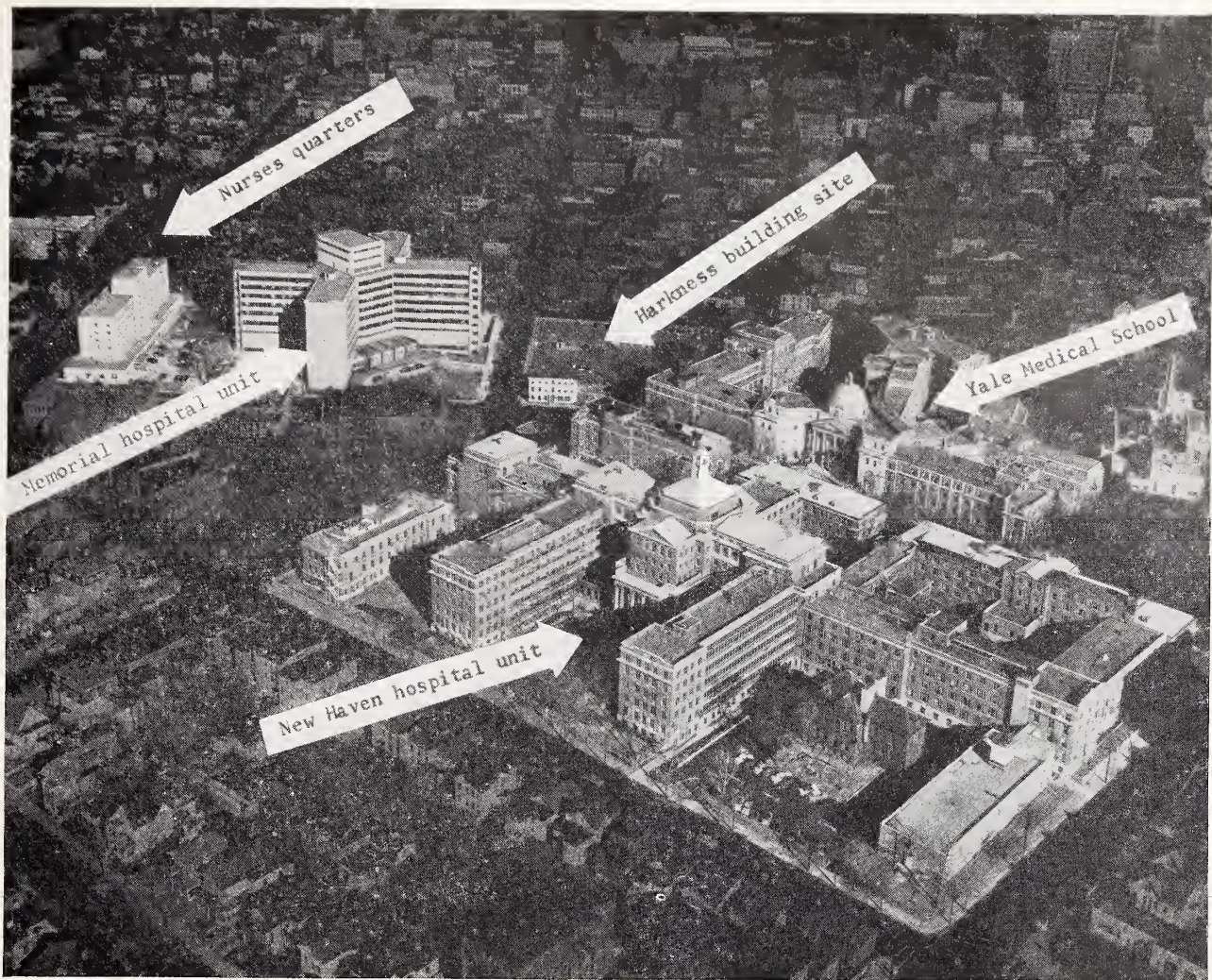


*Malley Photo*

#### HIRAM SIBLEY

Mr. Sibley, authority on hospital finance, has been named Director of Program Development of the Yale-New Haven Medical Center. He will resign as Executive Director of the Connecticut Hospital Association, a post he has held since 1948, to accept his new appointment.



*Fairchild Aerial Photo*

## AERIAL VIEW OF YALE-NEW HAVEN MEDICAL CENTER

This aerial view shows how the growing physical plant of the Yale-New Haven Medical Center covers more than three city blocks. The new Harkness residential building for the medical school will cover the entire triangular area (see arrow top center), and is expected to be completed by September, 1955. The new Grace-New Haven nurses building and the new Memorial hospital unit (see arrow top left) were both completed in 1953.

Members of the new Advisory Committee are: Dr. Vernon W. Lippard, dean of the Yale School of Medicine; Dr. Albert W. Snoke, director of the Grace-New Haven Community Hospital; Elizabeth S. Bixler, dean of the Yale School of Nursing; G. Harold Welch, New Haven banker and hospital trustee; Charles M. O'Hearn, assistant to the president of Yale; Dr. Gustaf E. Lindskog, professor of surgery; Robert E. Ramsay, president of the New Haven Gas Company and hospital trustee; Dr. Luther K. Musselman, chief of the hospital's general service staff; and Reginald G. Coombe, New York bank executive who is vice-chairman of the University Council and chairman of its Medical Affairs Committee.

Mr. Sibley's resignation as executive director of the Hospital Association will become effective one month following appointment of a new director to assure continuity of operation, it was announced.

The announcement of the new medical center plans and appointments was made jointly February 3 by President A. Whitney Griswold, Yale University, and President George S. Stevenson, Grace-New Haven Community Hospital. An immediate objective of the Yale-New Haven Medical Center plan, they explained, will be the development of a program of public relations, fund-raising promotion and program development. "The experience of other great medical centers," they said, "shows that hospital and medical school functions and activities cannot be



separated when presenting programs to the public. Strengthening and support of one of the partners materially assists the other."

Under the new plan the university and the hospital will retain their independent corporate structures, but will join forces in developing programs for medical research, teaching and hospital operation. The broad objective in the strengthening of the 128 year old partnership of the two institutions is the development of a major medical center for Southern New England similar in concept to the Columbia-Presbyterian Medical Center in New York City. As presently constituted, the Yale-New Haven Medical Center is concentrated within three city blocks in New Haven, where more than 3,000 physicians, nurses, laboratory technicians, and other personnel carry on its work.

Founded early in the nineteenth century, both the school of medicine and the hospital are among the nation's oldest medical institutions. Through efforts of the Connecticut State Medical Society and Yale College, authorization to establish a medical department was granted by the Legislature in October, 1810. Known as the "Medical Institution of Yale College," the department marked the beginning of medical education at Yale and it was jointly administered by the State Medical Society and the College through the following half century.

New Haven Hospital was established on its present site in 1826 by ten physicians, five of whom were members of the Yale faculty. They contributed their own funds to start the hospital, the fifth of its kind to be founded in the United States.

Grace Hospital, opened in 1892, was consolidated with New Haven Hospital in 1945, when both institutions were considering new building programs. Consolidation was effected under the corporate title of Grace-New Haven Community Hospital and funds were raised to construct the new Memorial Unit, completed early in 1953. The hospital now has a total capacity of 813 beds.

Plans for the Yale-New Haven Medical Center also comprise closer affiliation of the Yale and Grace-New Haven Schools of Nursing, the Yale Psychiatric Institute, the Yale Department of Public Health and the Child Study Center. Although Medical Center operations will accent the development of services already in existence rather than construction of new buildings, the physical plant is continuing to expand. The hospital's new 10 story Memorial Unit represents a major addition to its facilities and the Yale

School of Medicine has received \$2,750,000 from the Commonwealth Fund to construct a residential unit for medical students. To be known as the Edward S. Harkness Memorial Hall, the new structure is scheduled for completion by September, 1955.

Mr. Sibley will continue his close association with hospital and medical care programs in his new assignment. He has served as secretary to the councils and committees of the Hospital Association and as the Association's representative on the Governor's Commission on Connecticut's Health Resources; the Advisory Committee of the State Health Department on Hill-Burton Funds; the State Board of Nurse Examiners, the State Education Department; the Licensed Practical Nurse Program; and several voluntary health agencies. He also has served as Coordinator for Hospitals, Connecticut Civil Defense Program, and as secretary of the Yale Department of Public Health, and lecturer on Public Health Administration. A graduate of Harvard University, Class of 1931, Mr. Sibley later attended the University of Rochester where he received the degree of master of arts in 1948. He also holds a master's degree in public health from Yale University and is a fellow of the American Public Health Association. Accomplishments of the Connecticut Hospital Association under his direction include the publication of a Cost Accounting Manual, the adoption of a Connecticut Blue Cross-Hospital Agreement establishing the basis of reimbursement as current hospital costs, the passage of a number of State laws including a cost reimbursement statute, a hospital licensing law, and a nurse scholarship bill, and the development of a statewide hospital public information program.

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### VA TB Case Finding Survey Program

The TB case finding program carried on by the Veterans Administration has been operating for four years now. During that period 3,217,000 persons have been screened for tuberculosis. These include 2,513,000 patients and 704,000 employees. VA has discovered 12,740 cases of active pulmonary TB and 34,470 inactive cases among these two large groups.

Nearly 91,000 other chest conditions were discovered during the last year of the survey. Also many important avenues have been opened up in the field of research for the use of the tuberculosis data developing from the program.

# THE HISTORIAN'S NOTE BOOK

JOHN HUXHAM, M.D., 1757

An Essay on Fevers

ARTHUR S. BRACKETT, M.D., *Riverside*

JOHN HUXHAM, who was a Fellow of the Royal College of Physicians at Edinburgh and of the Royal Society at London, had already published (about 1747) "A Small Volume of Observations of the Air and Epidemic Diseases." He read before the Royal Society a paper on the American method of inoculating against the smallpox by Dr. Benjamin Gale of Killingworth, Connecticut. Huxham paints a most interesting picture of the practice of medicine in the eighteenth century.

I was fortunate enough to find in an antique shop in Stamford, Connecticut, a "Huxham on Fevers," the third edition. The table of contents shows how much he had read and how busy he must have been. The footnotes are often in Latin, sometimes in Greek in the original language and letters. One seldom finds an index in old medical works. This book has an index of authors and subjects, plus an index of his "Dissertation on the Malignant Ulcerous Sore-throat." (See illustration.)

One is most intrigued by the description of a case where the ribs were affected by tuberculosis, a very rare lesion. There was also present a tumor as "big as a turkey egg." A summary of the physical symptoms of the case during the patient's sickness and a description of what Huxham found at autopsy follows in his own words.

"About Christmas 1728 Mr. T. . . ., a worthy sober Gentleman, about thirty, of a thin Habit of Body but a lively active Disposition, was seized with Pain in his right side, and grew a little feverish. He was bled by his Surgeon . . . but finding the Pain of his side daily increasing after about three weeks he consulted me.

"I found him under hectic Heats, a short cough and difficulty of breathing . . . He expectorated little, and that with Difficulty; and it was now sometimes tinged with Blood. I ordered him to be

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bled . . . in a few days he began to spit up a vast quantity of purulent, bloody, foetid Matter, which proceeded from a Vomica in the left lobe of the lungs; for he felt a Sorness in, and said that the matter came from, a Place to the left of the Sternum, towards the bottom of the Thorax. At length very little was expectorated . . . and I flattered myself with Hopes of his speedy Recovery. But notwithstanding all these promising Symptoms, the Pains in his right side still continued, exactly in the same place where it first began. . . . At last the Part began to swell considerably, and manifest signs of an Abscess came on. . . . In a few days the Surgeon opened it, from whence issued an immense quantity of purulent Matter . . . Upon further examination we found two of the Ribs foul and black . . . He, being exceedingly weak, hectic and emaciated, died March 29th, 1729.

"On examining the Body some of the intercostal muscles were black . . . the lower part of the pleura on the Right and diaphragm were quite black . . . A perforation entered the right Lobe of the lungs, which was purulent. In the left lobe we observed a Kind of Calosity, where probably the Vomica lay; and near the Vertebrae a large Tumour, bigger than a Turkey-egg, in a state of Suppuration. There were several other small Tubercles, some very hard, some full of Pus. Both lobes of the lungs were greatly diseased . . . They adhered firmly to the pleura in many Places.

"Probably some obstructions were formed in this Gentleman's lungs antecedent to the Pain of his Side, as he had been sometimes subject to a short dry cough; but I am persuaded the sharp Humor, that fell on the Ribs and intercostal muscles, by hindering free Respirations, greatly contributed towards the obstructions and supurations in his lungs; and by preventing also a due expansion of the thorax, it might increase the Adhesion of the lungs to the Pleura."

Evidently tuberculosis of the ribs is quite rare. The "worthy Gentleman" was lucky to live as long as he did, considering the treatment he got.

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The author wishes to acknowledge help by Mr. James Jeffrey, professor of surgery in the University of Edinburgh, Scotland.

## THE DOCTOR'S OFFICE

M. J. Carl Allison, PH.D., M.D. announces the opening of new offices for the practice of roentgenology and radiation therapy at Greenwich Towers, Greenwich.

Anderson W. Donan, M.D. announces the opening of an office for the general practice of medicine at Westover Road, Simsbury.

### A. D. A. Forecast

The American Diabetic Association publishes a bimonthly sheet known as *Forecast*, available at \$2 per year. It is edited by Frederick W. Williams, M.D., one of the founders of the American Diabetes Association, and has a distinguished medical Editorial Advisory Board which includes Charles H. Best, M.D., a co-discoverer of insulin.

Sample copies and subscription forms are available without cost to any physician for use with his patients. Many physicians have found it quite valuable to present a year's subscription to each new diabetic patient; the good will engendered has been well worth the nominal cost. Address American Diabetes Association, 11 West 42nd Street, New York 36, New York.

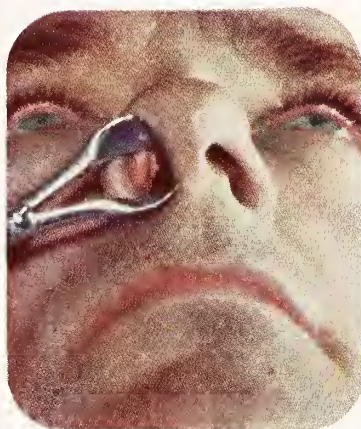
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## Special Article

### FINANCING HOSPITAL CARE

THE Commission on Financing of Hospital Care has published its "summary report" containing recommendations to the public, the principles which underlie these recommendations, and the highlights of the Commission's three study reports. It will be remembered that this Commission is an independent, non governmental agency sponsored by the American Hospital Association and established in November 1951 for a period of two years. Financing of the work of this Commission was made possible by grants from Blue Cross Commission, Health Information Foundation, John Hancock Mutual Life Insurance Company, W. K. Kellogg Foundation, Michigan Medical Service, Milbank Memorial Fund, National Foundation for Infantile Paralysis, and the Rockefeller Foundation for a total of \$556,000. The objective of the Commission was "to study the costs of providing adequate hospital services and to determine the best systems of payment for such services."

The "summary" report covers 76 typewritten pages. The full report will be published during 1954 in four volumes. The areas of greatest interest, as established by an analysis of questions asked at five regional conferences held throughout the nation were (1) voluntary prepayment, (2) improved methods of financing hospital care for groups unable to afford prepayment or in other ways to pay for care, and (3) why does hospital care costs what it does?

The Commission found that voluntary prepayment is an "effective method of financing community hospital services" which "greatly eases the burden of financing hospital care by making it possible to meet the cost through advance periodic payments of known amounts." "Its effect," according to the Commission, "is to reduce significantly the number of persons unable to pay for their care at the time of illness and the number for whom the community, through private or tax funds, must assume financial responsibility."

The Commission also found that "the financial stability of the voluntary hospital system is depend-

ent upon the degree to which voluntary prepayment enables both the general public and the hospitals to meet their common problem of financing hospital care."

Funds paid to the voluntary prepayment hospital plans, the Commission emphasized, are a "public trust" and "methods to assure economy and maximum effectiveness in their use are a joint obligation of hospitals, physicians, prepayment agencies and the general public."

Stress is given in the Commission's recommendations to development of measures for keeping prepayment costs as low as possible by eliminating unnecessary admissions to hospitals and by reducing unnecessary use of hospital beds prior to active treatment. The Commission suggested prompt discharge of patients after medical need no longer exists and the curtailment of unnecessary use of hospital beds for diagnostic and other services which can be given on an ambulatory basis as effective ways to reduce the cost to the public of prepaid hospital care.

The Commission found that "provisions for financing hospital care for persons receiving public aid are, in most communities, insufficient to meet the costs of necessary hospital care; and, in many communities, provisions for financing hospital care for other marginal income groups are nonexistent."

The Commission emphasized that, "If such groups as the aged, the unemployed, the disabled and low income, as well as public aid recipients, are to have access to needed hospital care, not only must additional funds be made available, but creative and imaginative approaches to financing and administration must be developed."

The Commission recommendations include specific guides for states and communities in determining the effectiveness of voluntary prepayment arrangements in their areas. Many of its recommendations, the Commission believes, are applicable to particular community situations and can be used by state and local study groups. Hospitals, physicians, prepayment agencies and other community groups, the



Commission suggested, should establish state and local study and action committees to work together to promote maximum coverage of the population.

Pointing out that a substantial increase in unemployment would create serious financial problems for the patient and the hospital, the Commission recommended several methods for extending voluntary prepaid protection into periods of unemployment. It felt that this could be done by voluntary action with prepayment plan and employer cooperation. The Commission proposed as one approach, however, the inclusion of voluntary prepayment costs in the unemployment compensation program.

Aged retired persons and the permanently disabled, the Commission found, need more hospital care than other groups and are less able to pay for it. The Commission made two major recommendations on this subject. One encouraged employers to make provision for coverage of retired employees under voluntary prepayment plans as part of their pension programs. The other proposed "inclusion of a provision in the Federal Old Age and Survivors Insurance program for hospital protection for needy beneficiaries receiving monthly income maintenance benefits under this program." The Commission recommended that the administration of such hospital benefits for OASI beneficiaries be the responsibility of state and local agencies and that protection be purchased from the voluntary prepayment plans or by payments directly to hospitals. For the low income group, composed of persons not on relief but unable to meet the cost of prepayment, the Commission proposed that governmental funds be used for experimentation in developing methods for improved financing of their hospital care through voluntary prepayment plans. Such funds should be administered, according to the Commission, by local agencies. The Commission observed that, to the extent low income families could be helped to budget for their hospital care through prepayment, dependency on local relief funds would be reduced.

For the groups now receiving public relief, the Commission proposed federal grants to the states and localities for a limited period of time to encourage assumption of state and local responsibility. The Commission emphasized its belief that these groups can be brought under voluntary prepayment plans.

Two members of the Commission, Mr. Ruttenberg of C.I.O. and Mr. Shishkin of A. F. of L. filed a minority report in which attention was called to the fact that the Commission had failed to recom-

mend a comprehensive system of social insurance covering the costs of hospital care, and had also failed to consider the possibility of a comprehensive national health insurance program. The Commission recommended the broadest possible pooling of risks and costs on a community-wide basis to maintain as nearly uniform rates as possible in order to achieve maximum population coverage including protection for those groups often not covered.

It also recommended that state and local groups, established to determine the effectiveness of community voluntary prepayment arrangements, develop and support methods for coverage of the self-employed, farm families, individuals not in employed groups as well as all classes of dependents of persons presently covered.

It was also urged that the area-wide study groups determine the prevailing benefit provisions available to persons in the community. The public should be informed of the basic benefit provisions which are required for adequate protection, states one of the Commission recommendations. In their recommendations to the public the Commission urged that state and local groups direct attention to:

1. Reduction in the multiplicity of benefit patterns.
2. Improved benefits to obviate the necessity for purchasing duplicate hospitalization protection.
3. Descriptions of benefit provisions which use non technical language.
4. Elimination of unnecessary and trivial special benefits which tend to obscure the real nature of the contract and fail to indicate the serious deficiencies and limitations of the essential benefit provisions.

The Commission reported that inflation, population growth, and increased number of admissions were important reasons for increases in total hospital operating expenditures. If the value of the dollar had remained unchanged from 1935 to 1952, the increase in total expenditures of all non federal general hospitals would have been only 199 per cent. If population had remained the same, the increase in total expenditures, after adjustment for inflation, would have been 148 per cent. Although hospital expenditures increased 199 per cent after adjustment for inflation, the concurrent increase in the total number of admissions means that costs per admission, after adjustment for inflation, rose only 20 per cent.

The recommendations of the Commission pointed out that many communities need more hospital beds but cautioned communities against over building

hospital facilities. Urging effective integration of services among community hospitals to avoid duplication, the Commission suggested that "before making capital expenditures for construction and equipment the hospital should carefully determine the needs of the community and its ability to finance the maintenance costs. Over building with attendant failure to make full use of bed capacity and diagnostic and therapeutic facilities should be avoided." The Commission stated that "methods which encourage early outpatient treatment may remove a later need for inpatient care" and that "prepaid benefit provisions for outpatient services as well as inpatient services will reduce the present demand for unnecessary inpatient care." The need for increased numbers of trained hospital administrative personnel was also stressed.

"As a means of reducing unnecessary and prolonged use of hospital beds," the Commission recommended that "hospital trustees, administrators and medical staffs join in efforts to promote early referral of patients to special facilities for the care of chronic illness, convalescence, rehabilitation or to home care programs." These special programs for long term care should be established by general and special hospitals or by other community groups and integrated with hospitals, according to the Commission. Hospitals should also cooperate in joint purchasing, training of interns and nurses, recruitment of personnel and efforts to obtain adequate community arrangements for financing care for public assistance groups.

### **Dr. Blasko New Mental Health Commissioner**

Governor Lodge has selected Dr. John J. Blasko, a top psychiatrist with the U. S. Veterans Administration, to become Connecticut's first state mental health commissioner.

The post, one of the most important in state service, carries overall supervision of the treatment of the some 11,000 patients at the State's three big mental institutions.

Dr. Blasko assumes his new duties July 1, leaving his present position as chief of psychiatric training, psychiatry and neurology service, Veterans Administration, Washington, D. C.

The selection of Dr. Blasko, who lives at Hyatts-



DR. JOHN J. BLASKO

ville, Maryland, culminated more than six months of intensive search for the best possible person to handle the new duties.

Dr. Blasko received his degree of Doctor of Medicine in 1935 from the St. Louis University School of Medicine. He interned at Christian Hospital, St. Louis, for one year and then entered general practice in 1936 in St. Louis.

From 1938-39 he was assistant physician at the Schuylkill County Hospital, Pa., and then became assistant physician, psychiatric resident and clinical director at State Hospital, Fulton, Missouri.

During World War II he was a medical officer at the U. S. Naval Center at Bethesda, Maryland, and as officer in charge of the psychiatric unit, Paris Island, Marine Corps Base, S. C.

Following his release from service in 1946, he was assistant medical director, City View Sanatorium, Nashville, Tennessee. In 1952 he was named to his present top Veterans Administration post which he is leaving to come to Connecticut.

In addition to supervising the treatment program at the state mental hospitals, Dr. Blasko will supervise overall training at the child study and treatment home.



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## STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., C.P.H., Commissioner

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### BRUCELLOSIS IN CONNECTICUT

JAMES C. HART, M.D., M.P.H., MILA E. RINDGE, M.D., M.P.H., D. EVELYN HIBBARD, B.S.,  
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**B**RUCELLOSIS, sometimes called undulant fever, is a disease which has been known for centuries in its clinical form, but it was only in the last century that the cause of the disease was determined. Bruce, in 1886, discovered the organism that produces the illness in human cases, and it is for him that the disease and the causative organism are named. Eleven years later, in 1897, Bang discovered the principal cause of contagious abortion in cattle. It was not until 1918, more than 20 years later, that Miss Alice Evans working in the old Hygienic Laboratory of the United States Public Health Service in Washington, D. C. proved that the two organisms discovered by Bruce and Bang were very similar, if not identical, thereby stimulating research that showed beyond question that Bang's disease of cattle was related to human brucellosis.

#### SYMPTOMS

Brucellosis in humans may cause either acute or chronic symptoms of illness. The incubation period varies from five to thirty days. The onset of the illness may be either sudden or gradual, with generalized aching, headache, loss of appetite, chilly sensations or frank chills, backache, pain in the muscles and joints, and fever. The temperature may rise to 104°-105° F. Drenching night sweats are common. Weight loss may be marked. Spontaneous recovery may occur in a few weeks, or the disease may persist for years with vague chronic symptoms or acute exacerbations. Mild forms with recurrent mild symptoms may occur and a malignant form with a high fatality rate has been described. Recent cases in Connecticut have been predominantly the chronic variety causing debility with no localizing signs—the type of case that persists for weeks, months or years and is diagnosed only with great difficulty.

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#### SUMMARY

Brucellosis has caused serious, disabling illness among residents of Connecticut during the past 26 years. During this time almost 1,700 cases have been reported to the State Department of Health. Analysis of 158 cases occurring from 1949 through 1952 shows a preponderance of male adults affected, especially among consumers of raw milk and individuals who work around cattle and swine. Identification of cultures from patients showed that 95.7 per cent were *Brucella abortus*, 3.7 per cent *Brucella suis* and 0.6 per cent *Brucella melitensis*.

*Brucella* infection has been widespread in dairy cattle in Connecticut. Bang's control programs have reduced the number of infected animals. The increase in pasteurization of milk and compulsory use of *brucella* vaccination of calves have been accompanied by a recent sharp drop in the number of reported cases of human brucellosis.

Complete pasteurization of milk for human consumption, and eradication of brucellosis of cattle by calf vaccination and blood testing programs are essential. Research investigations in swine brucellosis and protection of the slaughterhouse worker are also needed.

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#### THREE TYPES OF BRUCELLA

Three different species of the genus *Brucella* are known. *Brucella melitensis*, the caprine species,

primarily causes an infection of goats but can also infect humans as well as other animals such as pigs and cows. *Brucella suis*, the porcine species, which is the cause of Traum's disease in pigs, may also infect man and the other animals mentioned. *Brucella abortus*, the bovine species, primarily infects cows, causing Bang's disease, but it may also infect other animals and humans. In humans, infection with *Brucella melitensis* causes the most severe form of the disease and *Brucella abortus* the least severe type with the lowest fatality rate. Published articles<sup>1,2,3</sup> by the State Department of Health give further information regarding the three species of *Brucella* and the illnesses which they cause.

## EPIDEMIOLOGY

Brucellosis in man is ordinarily a disease of sporadic occurrence. The exceptions to this rule are:

1. The increased morbidity among those whose occupation brings them in close contact with farm animals, especially at time of slaughter.
2. The multiple cases which occur when the porcine or caprine species of *Brucella* contaminate dairy products which are not pasteurized before use.

Illness caused by *Brucella* is always traceable to infection in animals and is rarely, if ever, communicable from person to person. The attack rate is highest among packinghouse workers, veterinarians,

TABLE I  
LABORATORY EXAMINATIONS FOR BRUCELLOSIS, 1926-1952

YEAR	BLOOD SERUM AGGLUTINATIONS	BLOOD CULTURES		OPSONOCYTO- PHAGIC TESTS <sup>2</sup>	CULTURES FOR CLASSIFICATION (FROM APPROVED LABORATORIES)		MILK SERUM AGGLUTINATIONS	MISCELLANEOUS AND EXPERIMENTAL TOTALS	
		WHOLE BLOOD	CLOTS						
1926 <sup>1</sup>	2								2
1927	16	2						1	19
1928	76	6						1	83
1929	267							1	268
1930	365	2						3	370
1931	763	7						11	781
1932	549	7						5	561
1933	650	2						9	661
1934	804	16			1			4	825
1935	1,075	5		18				1	1,099
1936	1,946	1		70			90	3	2,110
1937	1,981	1		237				1	2,220
1938	2,268			225				1	2,494
1939	2,538			173					2,711
1940	3,048	2		324	1				3,375
1941	4,256			369			1		4,626
1942	3,715			276			2		3,993
1943	3,214		14	210			416	1	3,855
1944	3,171		2,072	167			1,138	1	6,549
1945	4,509		3,247	377			677	3	8,813
1946	6,845		6,117	924			391	8	14,285
1947	9,553		7,886	1,012	4		802	8	19,265
1948	8,849		7,509	604			586	1	17,549
1949	7,301		5,838	436			563	635 <sup>3</sup>	14,773
1950	5,970	1	5,327	201	1		671	3,820 <sup>3</sup>	15,991
1951	6,136		5,335	169	1		836	3,507 <sup>3</sup>	15,984
1952	5,797		5,222	159			858	182	12,218
Grand Totals	85,664	52	48,567	5,951	8		7,031	8,207	155,480

<sup>1</sup>No tests made prior to 1926

<sup>2</sup>Discontinued in 1953 because results proved of little clinical value

<sup>3</sup>Studies on media best suited for *Brucella*



livestock dealers, persons consuming raw milk particularly among farm families, and laboratory workers. In former years most of the cases in Connecticut were reported from persons who had been drinking unpasteurized milk from infected herds. Surveys<sup>4</sup> in other places than Connecticut of individuals who consumed unpasteurized milk have shown agglutination tests to be positive for *Brucella* infection in approximately 11 per cent and skin tests in 24 per cent of those tested. Following exposure to infection, some individuals react positively to serologic and skin tests without showing definite symptoms of illness. Only rarely can brucellosis be traced to the eating of cheese made from raw milk. However, *Brucella abortus* has been found to be viable in cheddar cheese infected with the organisms for as long as six months when kept at 4.4° C.

#### LABORATORY EXAMINATIONS

For many years the Bureau of Laboratories has been cognizant of the presence and threat of brucellosis to Connecticut residents and has made over 155,000 laboratory examinations on blood serum, whole blood and milk serum in an effort to track down the sources of the cases as they occur.

Table 1 shows the gradual increase in the examinations made for evidence of brucellosis, beginning with 2 tests made in 1926 and reaching a peak load of 19,265 in 1947. The different kinds of examinations and the numbers made each year are evident from the table. There has been a slight decline since 1947, undoubtedly reflecting the influence of calf vaccination and the more stringent regulation and control of milk and milk products in the various communities.

From the information in Table 2 it will be seen that the Bureau of Laboratories isolated its first culture of the *Brucella* organism from human blood in 1931. Laboratory search for *Brucella* in blood specimens was begun routinely in 1943 and is still a part of our everyday work. In all, 181 isolations, including eight received from approved laboratories, have been made and 176 have been typed according to species since typing was started in 1934.

In Table 3 the distribution of the occurrence of each species among the isolations is designated. The data are divided into two groups: (1) The isolations from 1943 through 1952 made in the Bureau of Laboratories in the routine search for *Brucella* in blood clots, and (2) the total isolations whether

TABLE 2  
BRUCELLA ISOLATIONS IN BUREAU OF LABORATORIES, 1931-1952

YEAR	SOURCE OF SPECIMEN			TOTAL
	WHOLE BLOOD	BLOOD CLOTS	CULTURES FROM APPROVED LABORATORIES	
1931*	2 (U)	Not done	0	2 (U)
1934	3 (U)	Not done	1 (A)	4 (3U, 1A)
1936	1 (S)	Not done	0	1 (S)
1940	2 (A)	Not done	1 (A)	3 (A)
1943	1 (S)	14 (12A, 2S)	0	14 (12A, 3S)
1944	0	14 (A)	0	14 (A)
1945	0	27 (A)	0	27 (A)
1946	0	25 (A)	0	25 (A)
1947	0	28 (A)	4 (3A, 1S)	32 (31A, 1S)
1948	0	14 (A)	0	14 (A)
1949	0	15 (A)	0	15 (A)
1950	1 (A)	10 (8A, 1S, 1M)	1 (S)	12 (9A, 2S, 1M)
1951	0	12 (9A, 3S)	1 (S)	13 (9A, 4S)
1952	0	4 (A)	0	4 (A)
Totals	9 (3A, 2S, 5U)	163 (156A, 6S, 1M)	8 (5A, 3S)	181 (164A, 11S, 1M, 5U)

\*No *Brucella* isolations prior to 1931

A = *Brucella abortus*

S = *Brucella suis*

M = *Brucella melitensis*

U = *Brucella*, species undetermined

from whole blood, blood clots, or from cultures sent from other laboratories in Connecticut. For purposes of comparison five cultures isolated in 1931 and 1934 (shown in Table 2) have been disregarded in this tabulation because they were not identified as to species. As is shown in the table the prevalence of each of the three species of *Brucella* is approximately the same for each grouping, with about 95 per cent of the isolations typed as *Brucella abortus* in both series. There have been 11 cultures of *Brucella suis* isolated and only one of *Brucella melitensis*.

TABLE 3  
DISTRIBUTION OF SPECIES IN BRUCELLA ISOLATIONS, 1934-1952

BRUCELLA SPECIES	ISOLATIONS FROM BLOOD CLOTS 1943-1952		ISOLATIONS FROM ALL SOURCES* 1934-1952	
	NO. OF ISOLATIONS	PER CENT OF TOTAL ISOLATIONS	NO. OF ISOLATIONS	PER CENT OF TOTAL ISOLATIONS
<i>Abortus</i> .....	156	95.7	164	93.2
<i>Suis</i> .....	6	3.7	11	6.2
<i>Melitensis</i> .....	1	0.6	1	0.6
Totals .....	163		176	

\*Includes 8 cultures received from local laboratories

Not shown in any of the tables are more than 20,000 agglutination tests made on routine blood specimens received in the Bureau of Laboratories during 1926, 1927 and 1928 from persons on whom tests were being made for another purpose. These blood specimens were tested as a cooperative project with the Connecticut Agricultural Experiment Station at Storrs as a feasible means at that time of gaining some idea of the brucellosis rate in man in Connecticut. The findings on the first 10,157 specimens were published<sup>5</sup> in the *American Journal of Public Health*; those on the last 10,102 specimens were published<sup>6</sup> in the *Connecticut Health Bulletin*. That survey was one of the earliest made in this country.

In evaluating results a very conservative yardstick was used; agglutination was not considered significant unless it was complete in dilutions of 1:100 or higher. Even so, 127 of the 20,259 specimens were found to react to that extent. This indicated an infection rate of 6 per 1,000 persons in the group tested. No record of the numbers of specimens showing weaker reactions has been preserved.

Judging from more recent experience, it seems reasonable to believe that the estimated brucellosis

morbidity rate should probably have been about twice as high as was indicated by the manner of interpretation used in the early survey.

As the State brucellosis control and milk pasteurization programs progress, the picture of laboratory examinations for brucellosis in Connecticut should continue to change, showing ever decreasing numbers of cultural isolations and serum reactions.

#### THE DISEASE IN CONNECTICUT

Human brucellosis in Connecticut was made reportable by sanitary code regulation<sup>7</sup> in 1928. Since then only one case of *Brucella melitensis* infection (proved by culture of the organism from the patient's blood stream) has been known to occur. This was in a 36 year old woman who became ill in October, 1949 soon after her return from a visit to Italy where she drank raw cow's and raw goat's milk. There have been no known cases of this form of the disease originating within Connecticut.

Eleven cases of human *Brucella suis* infection have

TABLE 4  
HUMAN CASES OF BRUCELLOSIS REPORTED IN CONNECTICUT

YEAR	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
1928	Made reportable August 14												
1929	—	1	—	1	2	—	2	1	3	1	2	—	13
1930	4	—	—	1	1	2	1	—	—	1	2	9	21
1931	2	2	2	3	2	1	2	1	—	—	3	2	20
1932	2	3	3	1	1	8	2	3	—	1	8	1	33
1933	4	4	4	2	1	2	—	4	5	4	5	1	36
1934	3	2	1	5	7	7	3	1	3	8	8	7	55
1935	4	3	2	5	2	3	4	7	2	6	13	8	59
1936	4	6	7	6	6	12	17	6	7	11	8	8	98
1937	8	2	3	8	9	3	6	10	9	5	4	7	74
1938	6	5	10	8	13	9	3	3	6	8	15	11	97
1939	5	6	6	5	4	11	5	5	5	8	4	6	70
1940	3	3	1	5	5	6	15	10	5	9	9	20	91
1941	13	7	3	14	17	10	15	8	9	11	10	6	123
1942	11	6	4	9	10	3	5	4	10	3	6	1	72
1943	3	5	4	6	7	4	6	7	11	7	7	7	74
1944	4	5	6	5	1	5	7	3	5	9	7	6	63
1945	10	8	11	8	17	6	12	9	6	18	8	13	126
1946	7	10	9	2	6	8	11	13	9	13	6	10	104
1947	3	10	20	19	22	32	19	9	16	17	6	5	178
1948	21	3	7	8	4	5	22	4	7	3	8	6	98
1949	4	21	7	22	10	4	—	3	2	1	2	2	78
1950	3	6	2	2	1	1	7	4	4	5	4	4	43
1951	3	—	7	—	—	—	2	3	—	2	—	5	22
1952	2	—	—	1	6	—	2	—	2	1	—	1	15
1953	—	3	2	1	4	2	4	3	2	2	3	1	27



been proved by blood culture in Connecticut since the disease was made reportable. Ten of these persons were Connecticut residents who were infected within the State. From three of these persons cultures were isolated during an outbreak of *Brucella suis* infection spread by unpasteurized milk at one of our institutions. This outbreak was described in an article published<sup>1</sup> at the time from the State Department of Health. No studies have been done to determine the incidence of infection in pigs in Connecticut and no coordinated efforts have been made to control this source of human disease.

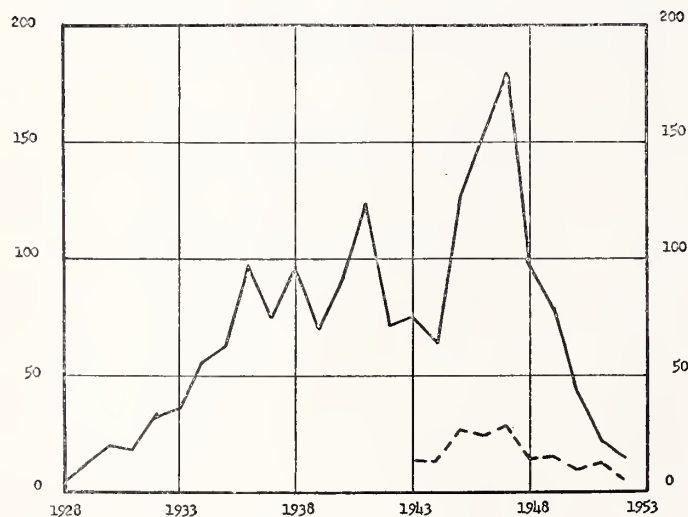
The remainder of the human cases proved by blood culture have been caused by *Brucella abortus*. However, all cases proved by blood culture were only about 16 per cent of the cases reported.

The number of reported cases in Connecticut (Table 4) rose irregularly from the time the disease was made reportable in 1928 until 1947 when it reached a peak of 178 cases. Since then the number of cases reported each year has dropped sharply. The accompanying Chart I shows this dramatically.

CHART I  
BRUCELLOSIS

HUMAN CASES REPORTED IN CONNECTICUT AND  
POSITIVE CLOT CULTURES

Human Cases ——— Clot Cultures — — —



1924—First case recognized in Connecticut

1928—Year Brucellosis made reportable

1943—Year New Britain pasteurization law became effective

1945—Vaccination of calves required

1948—Year pasteurized or accredited milk required in restaurants

1951—97.2 per cent of all milk sold in Connecticut pasteurized and 8 cities require pasteurization of milk sold within city limits

#### A DISEASE OF ADULTS

Brucellosis is frequently a disease of young adults and is found more often among males than among females. During the four year period, 1949 through 1952, a total of 158 cases of human brucellosis was reported to the Connecticut State Department of Health. Of these, 90 were male and 68 female. More than two-thirds of the cases reported were in persons between 20 and 49 years of age.

BRUCELLOSIS BY AGE AND SEX IN CONNECTICUT—1949 THROUGH 1952

	0-9	10-19	20-29	30-39	40-49	50-59	60	UNKNOWN	TOTAL
Male	2	4	12	27	21	16	8	0	90
Female	1	4	10	21	18	8	5	1	68
Total	3	8	22	48	39	24	13	1	158

#### HAZARDOUS OCCUPATIONS

It has been noted for many years that human brucellosis is found more often among certain occupational groups than among others. The occupational groups, as would be expected, are those concerned with or related to the handling of cattle. Among 126 cases reported to the Connecticut State Department of Health in the four year period, 1949 through 1952, (all of those on which the information is available) the following occupational groups were found: farmers—12 cases; farmhands—15; slaughterhouse employees—2; rendering plant employees—2; cattle dealers, buying and selling many cattle and visiting many farms—3; dealer in dairy equipment, visiting many farms and demonstrating his wares—1; sanitary inspector of a city health department inspecting slaughter houses and collecting milk samples from many farms—1; veterinarian—1; a total of 37 people intimately exposed to cattle. In addition there were 8 school children, 5 of whom lived on farms and were presumably infected from contact with the family cows or by drinking the unpasteurized milk. In three of these cases after the child became ill the cow was blood tested and proved to be infected. The largest occupational group was that of the housewife, with 39 representatives. Of these 8 lived on farms and are believed to have been infected by handling or using raw milk from the family cow. The remaining 42 persons were in miscellaneous occupations. One was a laboratory technician who was infected at his work and 26 others gave a definite history of consuming raw milk before the onset of illness.

## COMPENSATION FOR BRUCELLOSIS

At least 10 brucellosis patients, either farm hands or slaughterhouse employees, have been awarded compensation in Connecticut because of brucellosis contracted while at work. One case in recent years was that of a 35 year old farmhand who became acutely ill in September, 1948. This man was awarded payment by the Workmen's Compensation Commissioner. The claim of another farmhand was settled by stipulation for \$2,000.

In a number of instances court trials have followed brucella infections. In one case a 65 year old housewife who became ill in June of 1949 brought suit against the dairyman from whom she purchased raw milk. Milk serum agglutination tests done on milk from this dairy in August, 1949 showed two samples positive out of four tested. The outcome of this suit was not reported to the State Department of Health.

## BRUCELLOSIS COSTLY

The monetary cost of human brucellosis cannot be determined. In addition to the loss of wages and working time, medical expenses are high. At least 46 people have been hospitalized in Connecticut in the past four years because of brucellosis, with all the expense entailed in hospitalization. All have been seen several times by their physicians, and the drugs used in treating brucellosis are expensive.

While it is not common for humans to abort as cows do because of brucellosis, it is interesting to note that two Connecticut women in recent years have had abortions which may have been related to their illness. One was a 33 year old woman who became ill in July, 1950 and who is believed to have been infected by milk from the family cow. This woman miscarried during the acute phase of her illness. The other was a 23 year old woman who had miscarried in an earlier pregnancy and was threatened with a second miscarriage in August, 1951. She had none of the usual symptoms of brucellosis, but a blood test was strongly positive. The source of her infection is not known.

One death due to brucellosis occurred in Connecticut in October, 1948. This was a 72 year old woman who was infected by drinking raw milk during a visit to Maine in August, 1948.

## MILK SHOULD BE PASTEURIZED

There is no state law in Connecticut requiring the pasteurization of all milk sold. A law (Section

3235 of the General Statutes as amended by Section 1336c of the 1953 Supplement) which has been in effect since January 1, 1948 requires that all restaurants and public eating places dispense only pasteurized milk or milk from an accredited herd (regularly Bang's tested and found clean). Eight of the cities or towns in the State require pasteurization of all milk sold within the city limits. They are New Britain (the first city to pass such a regulation, in 1943), Hartford, Bristol, Waterbury, Meriden, Hamden, New Haven and Milford. In addition, Middletown requires that all milk be pasteurized or come from an accredited herd, and Greenwich requires that all milk be pasteurized or certified. Actually, at the present time over 97 per cent of all milk sold at retail in Connecticut is pasteurized. The milk sold raw is less than 30,000 quarts daily. Therefore, most of the milk consumers of the State are protected but, until the disease in milk- or meat-producing animals is eradicated, brucellosis will occur among persons who come in close contact with them or who drink infected, unpasteurized milk. When persons are found to have been infected by drinking raw milk the information is referred by the State Department of Health to the Commissioner of Agriculture for action as has been the practice for many years.

## CONTROL IN CATTLE

Blood testing of cattle for Bang's disease within Connecticut is not required by law. Under Section 3363 of the General Statutes, all dairy cattle are required to be tested before they are brought into the State. Two testing programs are offered to Connecticut cattlemen. They may be summarized as follows:

1. State and Federal Program—Dairymen in Connecticut are offered the opportunity of entering their herds in the state and federal program for the purpose of eradicating Bang's disease. In this program frequent blood tests are made and infected animals are slaughtered. The herd owner is reimbursed for the slaughtered animals by the state and federal governments.

2. State Program—If dairymen do not enter the state and federal program of test and slaughter they may enter the state program in which frequent blood tests are made and infected animals segregated from clean animals and held under quarantine, or sold into known infected herds where milk is pasteurized. All milk from infected animals must be pasteurized.

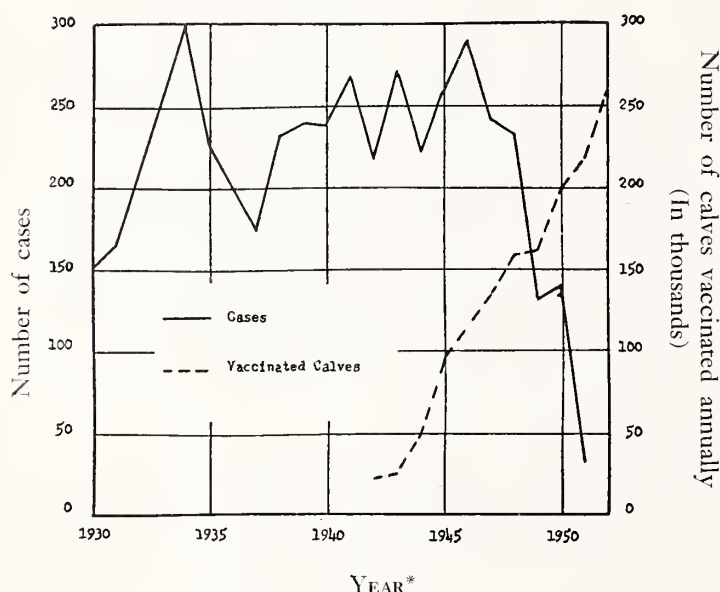


Calves in those herds are vaccinated between six and eight months of age.

Vaccination of calves against Bang's disease has been required in Connecticut since 1945. Public Act No. 337 passed by the 1953 General Assembly (Section 3329 of the General Statutes as amended by Section 1354c of the 1953 Supplement) states that "Each owner of bovine animals shall have all of his female calves vaccinated for the control of brucellosis between the ages of six and eight months."

CHART II

REPORTED HUMAN CASES OF BRUCELLOSIS AND NUMBER OF CALVES VACCINATED ANNUALLY WITH STRAIN 19 BRUCELLA VACCINE NEW YORK STATE (EXCLUSIVE OF NEW YORK CITY) 1930-1952



\*Cases based on calendar year

Calves vaccinated based on fiscal year

Reproduced from Health News, Vol. 29, July 1952, page 12, published by New York State Department of Health.

By referring again to Table 4 and Chart I showing the reported incidence of human brucellosis in Connecticut, it will be noted that a sharp decrease in human cases has occurred since the peak year of 1947. This decrease followed by two years the time that calf vaccination was made mandatory in Connecticut and after most of the retail milk supply was pasteurized. This picture is true not only in Connecticut but also in neighboring New York State. Chart 2, which is reproduced from an article<sup>8</sup> written by Robert F. Korn, M.D., director, Bureau of Epidemiology and Communicable Disease Control, New York State Department of Health, shows the reported human cases of brucellosis and the number of

calves vaccinated annually with Strain 19 Brucella vaccine in New York State. Dr. Korn states in that article, "It seems likely that the explanation (of the decrease in reported human cases) is due in part, if not largely, to the development of an extensive calfhood vaccination program in New York State. This was started by the State Department of Agriculture and Markets in 1939, but only during the past three years has it begun to encompass the bulk of new calves born in the State. Last year 266,000 new calves were vaccinated, approximately 88 per cent of the total born. Quite clearly, this has reduced the amount of infection in the cattle and has sharply reduced abortions. It seems only logical that it should affect the reported incidence of brucellosis in humans. New York State probably has developed the most extensive program of brucellosis calfhood vaccination in the world."

#### CONCLUSIONS

1. Brucellosis has caused serious, disabling, costly illness among many individuals in Connecticut.

2. The vast majority of human cases have been of the long-standing chronic type of infection caused by *Brucella abortus* (about 95 per cent of the cultures isolated in the laboratory were typed as *Brucella abortus*). Until recently most of the cases in Connecticut occurred in persons who drank unpasteurized milk from infected cattle. The latest cases have usually been in individuals with a history of having handled infected animals.

3. The decrease in the number of reported cases in the past few years has been associated with the increasingly high percentage of pasteurized milk sold in the State and with increased calf vaccination.

#### RECOMMENDATIONS

1. All milk sold in the State should be pasteurized. Milk products should also be made of pasteurized milk.

2. All herds of cattle should be protected by calf vaccination in combination with the federal and state testing program for brucellosis control.

3. A survey of brucellosis among Connecticut pigs should be made with a view of applying control measures.

4. Slaughterhouse workers should be protected from brucellosis by proper equipment and sanitary facilities.

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many names. Connecticut State Department of Health, Bureau of Preventable Diseases Educational Pamphlet 35, June, 1950.

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### Dr. Albert Keith Honored

The New England Proctologic Society met October 30 at the Lord Jeffrey Inn, Amherst, Massachusetts for its semi-annual meeting and election of officers.

At this meeting a silver plate was presented to the retiring president by its members, upon which was carried the following:

"The New England Proctologic Society

1937

E Tenebris in Lucem

Albert R. Keith, M.D.

Physician and Surgeon—American and New Englander Pioneer in Proctology. Founder and president for 16 years of the N.E.P.S. We the members of the N.E.P.S. on October 30, 1953 honor him with this memento in appreciation of his untiring efforts in promoting proctology, for his inspiration in guiding this society, and his council and kindness to us all."

Also on the plate are carved the names of the charter members and of all the active members.

Following a bountiful banquet, scientific papers were read and the following men were elected, President, J. Grady Booe, Bridgeport, Connecticut and Secretary and Treasurer, Jasper Angelo of Boston, Massachusetts.

### Conference Committee With Legion Meets

Transferring the treatment of veterans with non-service connected disabilities from Veterans Administration facilities to the general hospitals in their communities would eventually provide better health care for everyone was emphasized by Dr. Russell B. Roth, member of the American Medical Association's Committee on Federal Medical Services, at a meeting of the Society's Conference Committee with representatives of the American Legion in New Haven, January 18. The Erie, Pennsylvania physician declared that the stand adopted by the AMA House of Delegates to curtail treatment of non-service connected disabilities in VA hospitals does not mean depriving veterans of adequate care, but envisions the expansion of local hospital and medical facilities which would also provide better care for the dependents of veterans. It is fully realized, he said, that any such transfer of responsibility must evolve gradually because of the time that would be required to plan and develop additional local facilities.

Dr. Irving B. Brick, Washington, D. C., medical consultant for the National Rehabilitation Committee of the Legion, voiced belief that adoption of the AMA proposal would mean wrecking the present system of medical care for veterans. He maintained that this would result because the veterans hospitals would lose the large number of general medical and surgical cases in the nonservice connected category with consequent impairment of residency training programs. He pointed out that this would mean less satisfactory medical care for veterans with service connected disabilities, inasmuch as it would adversely affect the organization and competence of VA medical staffs.

Speaking about the controversies that have developed in connection with the extent of care being furnished veterans with nonservice connected disabilities, C. Joseph Stetler, secretary of the AMA Committee on Federal Medical Services, declared that differing methods of statistical research were the causative factor. In this way, he said, figures compiled by the Veterans Administration indicate only a 10 per cent load of nonservice connected cases. He contended that the procedures used by the AMA Committee on Federal Medical Services are more realistic and that these indicate that approximately 85 per cent of VA hospital patients are in nonservice connected categories.



Dr. George H. Gildersleeve, the Society's president and chairman of the Conference Committee, then called upon other conference members to express their views. Dr. E. M. Andrews raised the question whether it is the responsibility of the Veterans Administration to engage in medical education. He pointed out such training programs must necessarily be restricted in scope since cases under treatment concerned only a segment of the male population and could not offer the broad general experience affecting all age groups and both sexes available in programs connected with community hospitals.

Dr. Norton Canfield expressed agreement with Dr. Brick's view that curtailing treatment of non-service connected cases would seriously affect the quality of the VA residency training program and jeopardize the present high standards of care for service connected cases.

Dr. Brick stated that widespread charges have been made, that some veterans abuse the VA inability-to-pay provisions in seeking treatment for non-service connected disabilities and questioned whether these charges represent any general feeling among physicians. Dr. Gildersleeve reported that in the Norwich area many physicians feel that this privilege is abused. Information on this point from other areas of the State was not available at the meeting.

The control of such abuses is considered to be very important by the American Legion and surveys that have been made in this connection have disclosed very few cases, it was pointed out by Colonel Clarence Scarborough, service officer for the Department of Connecticut, American Legion, and John H. Burke, the Legion's national field representative for New England.

The system employed to control such abuses at the State Veteran's Home and Hospital in Rocky Hill was explained by Francis E. Miner, administrator, who stated that the provisions concerning inability to pay effectively preclude any violations.

At this point Dr. Creighton Barker, the Society's executive secretary, requested that further information concerning the Rocky Hill Hospital and the Connecticut program for the care of veterans be made available for conference members. It was explained that the program and the modern hospital and residence facilities it comprises represent a highly effective project for the care of veterans that is unique among the 48 states. Members of the con-

ference expressed their interest in knowing more about the program and were invited by Mr. Miner to visit the facilities at Rocky Hill.

The operation of the new Veterans Administration Hospital in West Haven then came under discussion. Dr. Sydney Selesnick, director of professional services, outlined the operating principles of the hospital, with particular mention of the resident training program. The opportunities offered by the program are of special interest to him, he said, and represent a leading consideration for physicians to continue their affiliation with the hospital.

Dr. Joseph H. Bruno, also a member of the West Haven VA Hospital staff, expressed agreement with the views stated by Dr. Selesnick and contributed additional information concerning the operation of the hospital and the processing of veterans who apply for admission.

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### Grants for Leukemia Studies

Public Health Service has approved eight research grants, totaling \$704,563, in chemotherapy of the leukemias and related diseases. Favorable action followed a special mail poll of members of National Advisory Cancer Council, speed being important because this line of investigation was recommended last summer by Senate Appropriations Committee (it opens hearings February 17 on new PHS budget and will want to get a progress report). Sloan-Kettering in New York gets \$200,000; same sum (2 projects) for Children's Cancer Research Foundation, Boston; University of Utah (2 projects), \$60,000; investigators at Stanford, Columbia and University of Pennsylvania receive the rest.

### Miscellany

Talcums using 5 per cent boric acid powder are not a hazard, in the opinion of Food and Drug Administration. FDA made its decision after a long investigation, following charges that such preparations were harmful to infants. The FDA explains: "Clinical, animal, and chemical research investigations, as well as consultation with leading medical authorities who have conducted research in the field of baby talcs, confirm their safety." U. S. death rate in 1953 was 9.6 per 1,000 population, equalling record low rates achieved in 1950 and 1952. New consultants to Army Surgeon General are Drs. J. E. Dunphy and Neil L. Crone, both of Massachusetts.

## NEWS FROM WASHINGTON

### New Health Costs in Budget

The Eisenhower budget calls for a slight reduction in overall health spending for the year starting next July 1, but adds \$7 million cash, plus \$82 million contract authority for the proposed reinsurance and clinic-nursing home programs. The regular Hill-Burton program would get \$50 million, Institutes of Health about the same as this year, and VA a 10 per cent cut. The Department of Health, Education, and Welfare budget alone accounts for \$2,321,591,988. It is \$200,000,000 under estimated spending for the current fiscal year, mostly because of a cut in grants to states for public assistance. The following table lists major programs of HEW and medical items of other agencies, but does not include proposed armed forces spending for medical care.

	ESTIMATED FISCAL 1954	REQUESTED FISCAL 1955
Dept. Health, Education and Welfare .....	\$2,521,897,175	\$2,321,591,988
Public Assistance (grants to states) .....	1,340,000,000	1,200,000,000
Food and Drug Administration .....	6,280,200	6,245,000
Office of Vocational Rehabilitation .....	23,658,100	27,625,000*
Children's Bureau (grants to states) .....	30,000,000	30,000,000
Public Health Service .....	232,830,950	191,463,000
Assistance to states, general .....	13,525,000	15,039,000
Venereal disease control ..	5,000,000	2,300,000
Tuberculosis control .....	6,000,000	3,500,000
Communicable disease control .....	5,009,000	4,397,000
Hill-Burton hospital program .....	65,000,000	55,600,000†
Hospital and medical care	33,117,500	33,040,000
National Institutes of Health (operating expenses) .....	4,680,250	4,675,000
National Cancer Institute	20,104,775	19,730,000
Mental health activities ....	12,039,575	12,460,000
National Heart Institute ..	15,169,750	14,570,000
Arthritis and metabolic diseases .....	6,985,150	7,270,000
Microbiology activities ....	5,721,300	5,930,000
Neurology and blindness activities .....	4,501,750	4,763,000

### Veterans Administration

Hospital and medical care	693,000,000	694,000,000
Hospital construction .....	84,000,000	60,000,000
Atomic Energy Commission ..	26,000,000	27,000,000
Civil Defense Administration..	22,500,000	60,000,000
National Science Foundation..	8,000,000	14,000,000
Bureau of Indian Affairs.....	52,000,000	54,105,320

\*Includes a \$7,800,000 item for President's program of expanded vocational rehabilitation for the disabled.

†Includes a \$5,600,000 item for start of expanded program for clinics, nursing homes.

Note: President also requested a \$1,100,000 item to start proposed reinsurance of health programs.

### Veterans

President Eisenhower asks Congress for no change of policy on hospital care of nonservice connected cases. Funds are recommended for average patient load of 110,200, a 2 per cent increase over current fiscal year. To offset this increased cost, outpatient dental care program is to be drastically curtailed and o.p. medical services trimmed slightly. For fee-basis dental work, only \$5,810,000 is provided, compared with \$23 million this year. Fee-basis medical is cut from \$9.4 million to \$8.9 million. This year (ending June 30, 1954) private dentists will be paid by VA for 128,000 examinations and 207,000 treatments; new budget makes fee allowances for 12,000 examinations and 50,000 treatments.

For completion of 1,000 bed neuropsychiatric hospitals at San Francisco and Topeka, \$30 million is allocated. Salaries are provided for average of 136,000 employees in VA's medical and hospital programs, an increase of 3,000.

### Public Health and Research

U. S. Public Health Service gets \$226.1 million, a \$14 million cut compared with estimated expenditures in current year. Research grant programs (cancer, heart, etc.) are scarcely affected. But sharp cuts are made for tuberculosis and venereal disease control and construction of research facilities. As Federal contribution to Hill-Burton hospital expansion, \$50 million is provided—\$15 million below this year. However, White House is requesting Con-



gress to broaden scope of Hill-Burton, for which there is an additional budget request of \$62,650,000. This would cover \$60 million in construction grants for diagnostic-treatment centers, chronic disease hospitals, rehabilitation facilities and nursing homes, plus \$2 million for survey grants and \$650,000 administrative costs.

Also under head of new business: \$25 million as working capital for the agency President will ask Congress to set up to reinsure health insurance plans and guarantee loans by private capital to non profit plans. An estimate of \$1.2 million for administrative expenses is included. President also asks \$250,000 to finance a new National Commission for Health Improvement which, he said, "would have as its purpose the mobilization of private and public resources to seek solutions to the nation's health problems."

### New House Legislation

**HR6863—Social Security Extension.** (Curtis, R—Nebraska, January 6.) An attempt to streamline social security programs and to extend old-age and survivors insurance to about 5,000,000 more retired aged. Mr. Curtis, chairman of a subcommittee to make a fact-finding investigation of social security programs, claims his bill reflects his personal views, not the administration's, on social security. Coverage would be extended to practically all occupations (including the medical profession) now excluded. Coverage provisions are virtually identical with HR6812 introduced August 3, 1953, by Daniel A. Reed, chairman of the Committee on Ways and Means.

The Curtis proposal would retain the present wage-related benefit structure by: (a) continuing monthly payments up to the present maximum of \$85; (b) increasing to \$45 the monthly benefits for all those now receiving less than \$45; (c) maintaining the contributory principle of the present law; and (d) continuing the present trust fund.

The present limit of \$75 a month maximum earnings for persons under the program would be increased slightly to \$1,000 a year, and would be computed on an annual basis instead of a monthly as at present. The bill also provides that social security payments be discontinued when a nonretired workers reaches 66 years and has paid for 40 quarters of coverage. To Ways and Means Committee.

**HR6949—Federal Health Service Reinsurance.** (Wolverton, R—New Jersey, January 6.)

This bill is similar to HR8746, introduced by Mr. Wolverton June 7, 1950. The new measure provides for the creation of an independent federal corporation in an attempt to facilitate broader distribution of health services. The corporation would be known as the Federal Health Reinsurance Corporation and would be granted a \$50,000,000 appropriation by Congress to start business. The health corporation would be similar to the Federal Deposit Insurance Corporation which protects bank depositors. It would safeguard voluntary nonprofit health insurance companies against heavy losses due to catastrophic illnesses thus enabling them to write unlimited coverage.

The federal corporation would repay the health service association  $66\frac{2}{3}$  per cent of claims in excess of \$1,000 paid in any twelve months. Premium charges for reinsurance of health service contracts would be 2 per cent of the total gross payments received by the health service association.

Three directors would be appointed for six year terms by the President of the U. S. and confirmed by the Senate. Examiners could inquire into the entire affairs of any participating health service association.

Contracts between an association and the federal corporation would require that an association limit its out-of-state subscribers to 25 per cent of its total membership, that the association will accept non group applicants, and that physicians and hospitals will agree to limit any additional charges to 25 per cent over an established fee schedule. A standard contract provision between the federal corporation and a health service association would require that premiums be based on the subscriber's income. No health plan would be permitted to pay its subscribers in cash benefits. A health service association could terminate its contract on 90 days' notice to the corporation.

Subscribers to health plans would be covered up to 75 per cent on the cost of twelve visits by a licensed physician and up to 95 per cent on the cost of all benefits furnished under any medical care contract. Operating expenses of the federal corporation would be covered—when necessary—by direct appropriations by Congress.

Health service associations could appeal corporation decisions to the United States Circuit Court of Appeals. To Interstate and Foreign Commerce Committee.

**HR6950—Permitting Government Loans to Nonprofit Health Associations.** (Wolverton, R—New Jersey, January 6.) Provides \$40,000,000 over the next five years for long term loans to assist voluntary nonprofit health service programs to obtain facilities and equipment. The association would have to submit to the Surgeon General evidence (1) of an organized structure headed by licensed members of the medical profession, (2) that compensation is satisfactory to participating physicians and to the governing board of the health plan, (3) that participation in the plan is voluntary.

A Health Services Facilities Council of 14 members would formulate standards with the Surgeon General for making loans to eligible health service plans. The council would be composed of one representative each from the Departments of Agriculture and Labor and 12 members appointed for four year terms by the Surgeon General. Three would represent medical service plans; three, national farm organizations; three, national labor organizations; and three would be members of the medical, dental, and nursing professions. To Interstate and Foreign Commerce Committee.

**HR6951—United States Mortgage Loans for Hospital and Medical Construction.** (Wolverton, R—New Jersey, January 6.) Amends the Hill-Burton Hospital Construction Act to provide mortgage loan insurance (similar to Federal Housing Administration type loans) to encourage private investment for the construction of medical facilities. Banks, investment houses, associations of physicians, and other groups would apply to the Surgeon General for insurance on loans for medical centers, hospitals, clinics, doctors offices, and other facilities. The bill requires that at least 75 per cent of any facility for which an insured loan is granted be devoted to serving members of a group practice prepayment health plan. Mortgages could not exceed \$5,000,000 and must be amortized within 25 years and interest rates are set at 5 per cent or less. Other measures with similar purposes were introduced during the first session. To Interstate and Foreign Commerce Committee.

**HR7113—College Education for Handicapped.** (Elliott, D—Alabama, January 11.) Provides federal aid to states that would set up college level education plans for physically handicapped persons between 16 and 45 years. The state plan would have

to establish "schedule of maximum fees for medical and surgical treatment, hospitalization and prosthetic devices." To Education and Labor Committee.

**HR7116—State Supervision of Union Health Funds.** (Hoffman, R—Michigan, January 11.) The bill is to encourage state supervision of labor union health and welfare funds by state insurance officers. To Education and Labor Committee.

**HR7199—The Administration's Social Security Extension.** (Reed, R—New York, January 14.) Would extend social security coverage, effective January 1, 1955, to an additional 10,000,000 persons, 6.5 million on a compulsory basis, including physicians and interns. (Ministers and certain state employees would remain on a voluntary basis.) This is the Administration's bill and includes in substance President Eisenhower's earlier views expressed in HR6812. Of about 12,000,000 not under social security, 450,000 are professional persons. In addition to coverage increases, the bill would:

(1) Raise benefits and increase from \$3,600 to \$4,200 the individual income limit on which the 2 per cent social security tax would apply—a \$12 annual per capita increase.

Also provides the ultimate tax rate for employees-employers would be 3½ per cent in 1970 instead of 3¼ per cent for employees-employers, and for a proportionate increase in the ultimate tax rate on the income of self employed.

(2) Eliminate the four lowest years of a worker's earnings in computing benefits. Under HR6812, the three lowest years would be dropped.

(3) Increase payments to all beneficiaries on the basis of a new formula which would raise the minimum primary benefits from \$25 to \$30 monthly and the maximum family benefit from \$168.75 to \$190.

(4) Permit retired persons under 75 to earn \$1,000 a year rather than \$75 a month.

(5) Preserve benefit rights if one becomes blind or totally disabled for an extended period by excluding the period of disability from computing average earnings. The impairment would have to be medically determinable and extend for more than six months. To qualify one must have been covered for at least one-half of the time in the 10 years preceding such period—20 quarters. The secretary of the Department of Health, Education, and Welfare would contract with state vocational rehabilitation agencies to determine disability. The state would



arrange to obtain the necessary medical evidence. Any individual who was dissatisfied with an unfavorable determination made by a state agency or the secretary of Health, Education, and Welfare would have the right to a hearing and judicial review. Disabled persons would be referred to state rehabilitation agencies for necessary rehabilitation services. To Ways and Means Committee.

**HR7200—New Formula for Federal Old Age Payments to States.** (Reed, R—New York, January 14.) Provides for technical changes to reduce, as the need declines, the federal government's cost of public assistance programs. Also relates federal grants to states' financial ability, thus resulting in higher federal allotments to low income states. The federal aid percentage would be from 60 per cent to 83 per cent. To Ways and Means Committee.

**HR7341—Amends Hospital Survey and Construction Act (Hill-Burton).** (Wolverton, R—New Jersey, January 18.) The Administration's bill (following President Eisenhower's health message) to enlarge the scope of the Hospital Act to include the construction of public and nonprofit diagnostic and treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes. It appropriates \$2,000,000 for state surveys of need for facilities and \$60,000,000 for construction over a three year period.

States would be allowed a minimum of \$25,000 for building surveys but would have to match the federal money equally.

The formula for construction grants would be based on a state's population and per capita income, as under the present Hospital Construction Act, with a minimum allotment per state of \$100,000 for diagnostic or treatment centers and chronic disease hospitals and \$50,000 for nursing homes and rehabilitation centers. The federal share would range from 50 per cent in high income states to 66⅔ per cent in low income states. The public or nonprofit agencies sponsoring the construction project would have to match the federal donation.

New construction would have to comply with present regulations for hospital projects except that the present requirement for states to set enforceable maintenance and operating standards would be omitted (except for chronic disease hospitals). State agencies would recommend and approve all construction, and the act would be administered by the

U. S. Public Health Service. The \$60,000,000 for 1955, 1956, and 1957 would be divided as follows: \$20,000,000 for nonprofit diagnostic or treatment centers, \$20,000,000 for nonprofit chronic disease hospitals, and \$10,000,000 each for nonprofit rehabilitation facilities and nursing homes. To Interstate and Foreign Commerce Committee.

### **AMA Indorses Bill for Expanded Hill-Burton Program**

The American Medical Association has given its formal indorsement to the first of the administration's health bills, a 3 year, \$60,000,000-a-year program for Hill-Burton grants to build nonprofit facilities for the chronically ill, nursing homes, diagnostic or treatment centers and rehabilitation units. The Association's position was outlined in a letter from Dr. George F. Lull, AMA secretary and general manager, to Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee. The committee opened hearings on the bill (HR 7341) February 4, immediately after winding up an extensive fact-finding study of health problems. The first witness was Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, who urged favorable committee action.

The AMA recommended that: (1) facilities for the chronically ill and impaired should be part of or near a conventional hospital, (2) the original purpose of the Hospital Survey and Construction Act (Hill-Burton) should be reaffirmed to make clear that any facilities built under the new program are for the benefit of the entire community.

Mrs. Hobby, in urging committee approval, summed up the measure: "On the solid base of the existing program it would add a five point plan for constructing the kind of health facilities which our communities most urgently need and which they can most efficiently and economically maintain." She described the Hill-Burton program as "one of the most successful and popular health programs ever initiated by the federal government." Other points made by the Secretary:

(1) Greatest need lies in facilities for chronically ill. Since 1948 there has been a net loss in the number of hospital beds for care of patients with chronic diseases, including cancer, arthritis, and heart disease.

(2) The need for institutional bed care must be minimized by placing greater emphasis on preven-

tive health services. Under the current program relatively little attention has been given outpatient departments of hospitals and other diagnostic and treatment centers. There is no reason why many communities with no hospitals could not build such centers for the community and surrounding rural areas.

(3) State Hill-Burton plans will have to be revised to conform to HR7341, since three of the four construction categories covered by the bill are new.

Secretary Hobby and Surgeon General Leonard A. Scheele estimated that \$36 million in combined Federal-state funds would build 2,770 chronic disease hospital beds, and that \$18 million could provide 2,250 nursing home beds. This is based on an estimated average cost per bed of \$13,000 and \$8,000, respectively, compared with \$16,000 per bed in a general hospital. But cost would be still less where the facility was built as a wing of an existing hospital, rather than as an independent unit, it was explained.

**HR7448—Children's Service Act.** (Reed, R—New York, January 21.) Amends Social Security Act according to President Eisenhower's recommendations by replacing the present separate categorical grants for maternal and child health, crippled children's, and child welfare services, with three types of grants:

(1) General assistance to states to finance their child health and welfare services. The formula for determining each state's allotments would be similar to that used in the Hospital Survey and Construction Act in that it would consider the relative child populations of the states and their per capita incomes. Each state would have a minimum of \$200,000 with state shares from  $33\frac{1}{3}$  per cent to  $66\frac{2}{3}$  per cent.

(2) Six year grants to aid states to extend and improve child health and welfare services. A minimum allotment of \$5,000 per state with the federal share up to 75 per cent for the first two years, 50 per cent for the next two, and 25 per cent for the last two.

Of each state's allotment in the type (1) and (2) grants, 32 per cent would be for maternal and child health services, 29 per cent for crippled children, 19 per cent for child welfare. The remaining 20 per

cent would be allocated among these services by the state governor.

(3) Grants to states and public and nonprofit institutions of higher education to meet the costs of projects to solve child health and welfare problems of national significance. For the first three fiscal years 10 per cent of a state's annual appropriation would be available for these projects.

To receive federal allotments, a state would have to submit plans to the Secretary of Health, Education, and Welfare for its individual child assistance programs.

To permit states to adjust to the new allotment formulas, a limit of 10 per cent would be put on any decrease in allotments to a state in any one year.

The bill authorizes \$41,500,000 to be appropriated annually, the same amount as at present, but the Administration estimates only \$30,000,000 will be needed, the same as currently.

The amendments would become effective July 1, 1955. To Ways and Means Committee.

## Tax Deductions

The House Ways and Means Committee voted to increase tax allowances for medical expenses by providing that medical costs can be deducted from taxable income if they exceed 3 instead of 5 per cent of adjusted gross income.

Maximum limitations for deductions would be doubled from \$1,250 to \$2,500, multiplied by the number of exemptions, with a limitation of \$5,000 on single taxpayers and \$10,000 for heads of families or married couples filing a joint return. These limits also double those in present law. The tax loss is estimated at about \$119,000,000.

Under the new proposal costs of medicines and drugs could be included in medical expenses only to the extent these items exceed \$50 or 1 per cent of adjusted gross income, whichever is greater. At present it is generally accepted that all medicines and drugs can be included. The government expects by this change to add \$40,000,000 in tax money.

Transportation expenses, where travel is prescribed by a physician, could be deducted but not the cost of meals or lodging. A decedent's medical expenses also could be deducted if paid by his estate.



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## PUBLIC RELATIONS

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### New Haven Emergency Medical Service Records Thousand Calls in First Ten Months

More than one thousand calls for medical attention and information were received by the emergency medical service sponsored by the New Haven Medical Association during its first ten months of operation.

The 1,056 calls that were serviced included 181 requests for information and the remaining 875 calls were for emergency medical attention, according to a report prepared by Samuel Spinner, chairman of the Association's Emergency Medical Service Committee.

The report points out that 58 per cent of the calls for medical attention were considered true emergencies by attending physicians. It is recommended that in the remaining 42 per cent of calls that were not considered emergencies a continuing program of public education be directed toward reducing their incidence.

The emergency calls averaged approximately 90 per month and in one-third of the cases patients reported they did not have a family physician.

The system was inaugurated March 8, 1953, with a roster of 70 physicians who volunteered to participate in rotating emergency panels to provide emergency medical attention. The plan is so organized that calls received during the day are directed to panel members whose offices are in the vicinity, while night calls are serviced by physicians who reside near the scene of emergency.

### Litchfield County Sponsors Press-Radio Conference

A conference to explore ways in which relationships with the press and radio can be improved to assure adequate reporting of medical and hospital news was sponsored by the Public Relations Com-

mittee of the Litchfield County Medical Association, February 4, in Torrington.

James C. Canniff, Torrington, chairman of the committee, presided at the conference held at the Conley Inn, and those in attendance included representatives of the press, radio and hospitals in the Torrington-Winsted area.

Problems encountered in the assembling of medical and hospital news were discussed at length and conference members expressed interest in the development of a press-radio code similar to those that have been established in cooperation with medical associations and hospitals in a number of other communities. It was agreed to obtain sample copies of such codes for study by members of the conference and to further explore the proposal at a subsequent meeting.

### New AMA Committee Appointed to Study Adverse Publicity

The Board of Trustees of the American Medical Association has appointed a five member committee to study all aspects of the public relations problems created by adverse publicity.

The following physicians were appointed to the committee, with the prospect that two more members may be added at a later date: Stanley R. Truman, chairman, Oakland, California; John S. DeTar, Milan, Michigan; Leland S. McKittrick, Brookline, Massachusetts; James Q. Graves, Monroe, Louisiana; and Felix L. Butte, Dallas, Texas.

Appointment of the committee is in accord with a resolution adopted by the AMA House of Delegates in St. Louis last December. Introduced by John F. Burton, Oklahoma, the resolution referred specifically to "published statements of certain medical spokesmen concerning alleged unethical practices by members of the medical profession" which have "tended to destroy the confidence of patients in their physicians, without solving the basic problems involved."



The committee has been instructed to report its findings and make whatever recommendations deemed necessary to the next meeting of the House of Delegates, to be held in San Francisco next June.

### Greenwich Medical Society Sponsors New Emergency System

Modification of the emergency medical call plan sponsored by the Greenwich Medical Society to provide more complete 24 hour service was recently announced.

Known as the Emergency Call Panel, the service operates through a central telephone switchboard where trained operators have access to a list of physicians available for emergency calls.

A report concerning the service in the *Greenwich Time* states the system "fills the gap in those few instances in which neither the family doctor nor his substitute is available and the patient can't wait. It will also locate a doctor in an emergency for newcomers or others who may not have a regular family physician."

### Statement on President Eisenhower's Health Plan by AMA Board of Trustees

The Board of Trustees of the American Medical Association has given careful study to the President's Message on Health delivered to Congress on January 18. The Board is pleased to find in this message so many of the ideas and principles for which the American Medical Association has striven for so many years.

The Board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled.

There are certain basic principles which the American Medical Association feels are essential in the consideration of any voluntary health insurance program: there must be free choice of physicians and hospitals; the program must be founded on sound actuarial data and there must be no direct or indirect control of the program by the government.

The Administration's federal reinsurance proposal is indefinite. It is not clear whether this is true reinsurance or another form of government subsidy. This whole subject needs careful study and until the plan is spelled out in detail the American Medical Association can make no further comment.

The American Medical Association feels that there may be other approaches to the problem of the extension of health coverage than that of federal reinsurance. For example, the AMA has strongly supported legislation to permit deduction from income for tax purposes of medical and hospital bills and premiums paid for voluntary health insurance.

### Killing The Goose

Michigan Hospital Service has made a survey to show up the errors in the utilization of hospital services under prepaid plans. The same type of faulty use was found in commercial carriers as in Blue Cross.

12,000 consecutive, completed, clinical case records from representative areas were studied.

18 per cent of Blue Cross cases overstayed a total of 2,516 days.

14.7 per cent of commercial insurance cases overstayed a total of 1,115 days.

7.3 per cent of self-payment cases overstayed 470 days.

1 per cent of welfare cases overstayed 68 days.

Hospitalization for medical inventory or diagnostic procedures alone showed the following:

11.7 per cent Blue Cross cases used 2,515 days.

10.5 per cent commercial insurance cases used 1,034 days.

4.4 per cent noninsured cases used 538 days.

Hospitalization for convenience revealed the following:

Of 4,370 Blue Cross cases studied, 154 used up 750 days.

Of 2,418 commercial insurance cases, 62 used up 240 days.

Of 156 welfare cases, five used up 21 days.

The Michigan editor remarks: "If these two great services (Blue Cross and Blue Shield) fail, government management will surely be demanded and will be unhesitatingly assumed. If this great and grand experiment fails, it will be because the incipient evils were not foreseen and promptly corrected by the only persons who can keep the services well—the M.D.'s. It is in the province of the Doctors of Medicine to keep the Blue Cross-Blue Shield strong bulwarks against socialism."

(Very true. Ed.)

## FROM OUR EXCHANGES

Jensen in "En Klinisk Undersogelse over de Oestrogene Stoffers Betydning for Cancer Corporis Uteri" (*Ugeskrift F. Lager* 115:52) reports the result of a study of 105 cases of endometrial carcinoma which showed that in these patients the menopause commenced later and was more often preceded by periodic metrorrhagia and less frequently accompanied by hot flushes than in the average climacteric woman. This indicated to the author that these patients have often been under the influence of endogenous estrogens throughout longer periods than the average woman. In spite of this those with cancer of the uterus in this study frequently gave a history of estrogen therapy in larger amounts and for longer periods than recorded in the control patients.

\* \* \* \*

Patients with gastric resections should be followed up for at least 3 to 5 years after the operation because of the possibility of tuberculosis developing (Winslow, "Om Forbindelse Mellem Ventricelresection og Tuberkulose," *Ugeskrift F. Lager*, 115:52). The author found that out of 3,774 patients at a sanatorium, 33 had had a gastric resection done for peptic ulcer. Of these 33, 8 had been suffering from tuberculosis prior to the operation, progression of the lesion commencing one month to two years after the operation. Twenty-five developed tuberculosis after the operation in most of whom the possibility of preoperative TB could be excluded. In 15 cases the diagnosis of tuberculosis was verified 3 months to 3 years postoperatively.

\* \* \* \*

Nielsen discusses "The Management of Cerebral Vascular Accidents" in an interesting manner (*Ann. Int. Med.*, 39:4). He calls attention to the fact that cerebral vascular accidents are usually thought of as thrombosis, hemorrhage and embolism. There should be added to this list subarachnoid hemorrhage and subdural hematoma. In many instances neoplasms must be considered in the differential diagnosis.

Cerebral thrombosis is often heralded by recognizable signs hours or even days before it develops. The following points are helpful in making a diagnosis of cerebral thrombosis. (1) Thrombosis occurs

during rest and not during periods of physical activity. It is for this reason that it is more apt to develop at night. (2) Thrombosis does not occur suddenly. (3) In threatened thrombosis the spinal fluid may show at most a few red blood cells. Intracerebral hemorrhage of any size, on the other hand, results in a considerable amount of blood in the spinal fluid.

In the treatment of cerebral thrombosis it is well to remember that there is no method available for dissolving a blood clot in a cerebral blood vessel. The widely used methods of treating cerebral thrombosis with stellate block or the intravenous injection of procaine is effective only for threatened thrombosis. It is for this reason that the signs of an impending thrombosis should be familiarly known and watched for. Parasthesias, mild weakness, visual disturbances, and even episodes of hemiplegia commonly give warning of a developing situation before an irreversible thrombosis develops. It is in this preliminary phase of thrombosis that stellate ganglion block or the infusion of procaine solution is efficacious. The easier and less skilled method is the intravenous infusion of 500 mg. of procaine in 500 cc. of normal saline in two hours. According to the author, this is just as effective treatment as stellate block.

In cerebral embolism the intravenous infusion of procaine is a good treatment. However, it should not be overlooked that the fundamental problem is the discovery of the source of the embolism.

In the author's experience the sudden blowing out of a large vessel with a resulting massive hemorrhage is not common. The common thing, and the rule in traumatic intracerebral hemorrhage, is for a vasomotor paralysis to occur first and for the hemorrhage to be produced by diapedesis. Usually there is little that can be done in a massive cerebral hemorrhage. The patient is placed with the head elevated and with an ice cap to obtain vasoconstriction. Repeated spinal puncture is not encouraged on the grounds that it promotes bleeding. If the patient survives 24 hours, the prognosis is not hopeless; if he lives 48 hours, his chances for life are good but poor for function.

Congenital aneurysms of cerebral vessels present



many difficulties of diagnosis. Recurrent migraine syndromes that remain fairly fixed anatomically are a cause for suspicion. Such symptoms justify angiography. If aneurysm can be shown to be present, the case at once becomes a problem for the neurologic surgeon. The rupture or leak of such an aneurysm presents a new problem of diagnosis and of treatment. Actually the therapy in such cases is still to be worked out.

Subdural hematomas present a peculiarly difficult problem in localization and even in diagnosis. If the patient is in coma, all the difficulties are multiplied and it may be necessary to delay opinions until the case is thoroughly studied. If the findings are such as to indicate cerebral thrombosis, one can debate the wisdom of an angiogram and benefit from an injection of procaine. Sometimes an accurate localization of an intracerebral hemorrhage is possible and of a type amenable to surgical intervention.

A careful physical examination, a neurological examination, and a competent laboratory study will usually result in a well founded opinion as to what is wrong with the patient, even though he came under the care of the physician in a state of deep coma.

\* \* \* \*

Periodic health examinations are advocated by many doctors. Shillito (*Ann. Int. Med.*, 39:1), briefly enumerates the important factors in such an examination: namely, (1) periodic health examinations contribute materially to day-by-day health, by attention to minor deviations from the norm; (2) the original health examination should be a thorough health survey, with determination of "base-line" laboratory and x-ray levels for future reference; (3) subsequent examinations should stress health counseling and investigation of suspected conditions which have produced symptoms as elicited in an interval history.

\* \* \* \*

Fuchs interestingly discusses the origin and the function of eosinophilia as it occurs in health and disease (*N. Y. State Med. Jour.*, 53:14). The article may be briefly summarized as follows.

The exact role of the eosinophil in the physiologic and pathologic processes is unknown. There is enough correlation between eosinophilic levels in the blood and certain clinical states to make information about these cells useful to the physician.

Generally there is an increase in the total eosinophil

count in conditions associated with hypersensitive reactions such as those seen in allergic states and in parasitic infestations. Eosinophilia is commonly seen in certain destructive skin lesions, the "collagen" diseases, some poisonings and in conditions possibly related to foreign protein and sensitivity reactions. Eosinophilia is a feature of certain blood and marrow disturbances.

Stress phenomena caused by infection, surgical operations, and many other traumatic conditions characteristically cause an eosinophilia. Recovery from the stress state is marked by a return of the eosinophilia to normal or high levels. This return to normal does not occur if the adrenal cortex is not functioning properly.

\* \* \* \*

Within recent years the practice of human artificial insemination has become widespread. According to Schlemer, the situation has brought about a condition in which nobody knows much about the rights and liabilities of the parties involved because the question has seldom come up in the courts. Annulment, legitimacy, adultery, the effect of consent on legitimacy, the rights of the illegitimate child, inheritance, and even the question of rape all appear at sometime or another to have entered into the problem. It is obvious that the whole problem is not a simple one and that the doctor should consent to such a venture only under circumstances that fully guard his good name and his future liability.

Dr. Schlemer concludes that the physician who performs the insemination, the husband and the wife, the child and the donor are all in an unsatisfactory position with respect to the law. Statutes will have to be enacted either regulating the practice and outlining the rights and liabilities of the parties concerned, or making the practice a criminal offense. As a practical matter the author does not believe that it will be made a criminal offense, for the reason that the practice has become too widespread, and the judicial comment in this country has been too favorable.

The status of the child conceived by aid is a problem that will be solved by statutory determination, and it suggests some interesting possibilities. The author's own conclusion is that adoption is the best way to bring wanted children into the childless home.

Any doctor that goes to the trouble of reading

this article on "Artificial Insemination and the Law" will not undertake the practice either lightly or without fully guarding himself from legal difficulties. The complications of what is undertaken as a favor are not only numerous but are obscure.

\* \* \* \*

A timely editorial appears in the September issue of the *Journal of the Michigan State Medical Society* entitled "Muckraking" (52:9). The editorial mourns the fact that 98 or 97 per cent of the physicians who are doing an amazing job for our public should suffer for the faux pas of the heedless few. The bad public relations of the medical profession are due to the mispractice, misconduct and ill advised remarks or actions of the few. As long as these nonconforming members—not more than 2 or 3 per cent—continue to make mistakes the muckraking will continue.

For the wellbeing of the medical profession it is important that the individual doctor must see and continue to be his ultimate best.

\* \* \* \*

Joslin is of the opinion that the diabetic should be as safe in the home as in the hospital (*Penn. Med. Jour.*, 58:5). This ideal is possible only if the diabetic and his family receive education—primary, secondary and postgraduate. Dr. Joslin considers that the major endeavor in diabetes today is the establishment throughout the country of hospital teaching centers to which ambulatory and hopeful patients can return frequently at lessened hospital costs and learn not only their status but gain new information for better results. Diabetics, like doctors, in this forward-changing world need postgraduate education. Dr. Joslin considers that we have today full proof that the control of diabetes pays.

\* \* \* \*

"Current Concepts in Diabetes Mellitus" is a frank attempt to ferret out many of the mistakes that are commonly made by patients in the management of their diabetes. The physician must often act like a first grade detective in discovering these errors. Graef briefly sums up these errors in the following list (*N. Y. State Jour. Med.*, 53:14).

- (1) The physician should be thorough in his original instruction.
- (2) The physician should be repetitious at follow-up visits, almost making a catechism of his instructions.

(3) Make sure that the patient has the means of performing urine sugar and acetone determinations at home (clinitest and acetest tabs).

(4) All patients with diabetes, whether on insulin therapy or not, should have a bottle of regular insulin at home and should be instructed in the use of the same.

(5) The patient should be taught how to take his temperature.

(6) The doctor should be available for telephone contact by the patient so that he may get proper instruction in case of emergency, or even in case of doubt.

\* \* \* \*

"The Significance of Cell Types in Bronchogenic Carcinoma" is an analysis by Moersch and McDonald of 1,000 cases of proved bronchogenic carcinoma as they were observed in the Mayo Clinic (*Dis. of Chest*, XLII:6).

The cell types were as follows: small cells in 90 cases (9 per cent), adenocarcinoma in 137 cases (13.7 per cent), large-celled carcinoma in 395 cases (37.8 per cent), and squamous cell carcinoma in 395 cases (39.5 per cent).

Small cell carcinoma and squamous cell carcinoma occur much more frequently in men than in women. The average age of the patients was slightly lower in the cases of small cell carcinoma than it was in the cases of the other types of tumor.

The duration of symptoms was shorter in cases of small cell carcinoma than it was in cases of the other types of tumor. In all the cases of small cell carcinoma the patient had symptoms that were referable to the thorax. Such symptoms were not present in all of the other types of carcinoma.

Roentgenographic examinations of the thorax disclosed an abnormality in all but 12 of the entire series of 1,000 cases. Bronchoscopy was not performed in all the cases studied, but was effective as a diagnostic procedure in those cases in which the tumor arose from the central portion of the lung. Cytologic examination of the sputum or bronchial secretions was more effective in the cases of small cell carcinoma and least effective in the cases of adenocarcinoma.

The results of surgical treatment were more satisfactory in cases of squamous cell carcinoma than they were in cases of the other types of carcinoma. The results of surgical treatment were least satisfactory in the cases of small cell carcinoma.



## CMS REPORT BY THE PRESIDENT

ROBERT S. JUDD, *New Haven*

Connecticut Medical Service, Inc., has had a good year. We are happy to be able to report for the year 1953 a gratifying record of steady growth in members to a new total of over 697,000 as of December 31, with a correspondingly improved financial balance sheet, a new contract offering, and an organization that promises well for further development of service and extension of coverage.

A significant development of the year was the final termination, by mutual agreement, of the exclusive Agency Contract with Connecticut Hospital Service. We have now assumed complete operation of all functions of CMS with our enlarged organization housed at 205 Whitney Avenue, occupying the entire building of three floors under a ten year lease. We are satisfied that, in consideration of present growth and financial standing, we can better serve the public and more adequately represent the medical profession. We plan to promote sales of our contract independently or in association with Blue Cross or other hospital coverage to meet any demand. Under this new Policy we retain complete control of our own contract.

The continuing support of our Participating Physicians, a group of 2,138 or approximately 85 per cent of those eligible in Connecticut, still provides the essential guarantee of Service Benefits. These physicians are regularly accepting as full compensation, for surgical, medical and maternity cases for members within the Service Benefit income brackets, fees that are often below what these doctors would otherwise charge for the same services, a very real contribution by them to make the best medical service available to lower income people. The Participating Physician receives payment of claims directly and promptly. A total of 101,534 claims were paid during the year amounting to over \$5,700,000. Of these claims, 53 per cent qualified for Service Benefit and the published schedule fees were accepted by the attending Participating Physician in full payment. These doctors have made the term Service Benefit meaningful to many hundreds of grateful patients, CMS members.

The members of the Professional Policy Committee, nominated by the State Medical Society, take their responsibilities, as representatives of the medical profession, very seriously and have devoted long hours of study to the revision of the professional features of our contract and fee schedule. Their decisions, tempered by broad knowledge of the tenets of American medical practice and with discernment of the delicate balance between theory and practical facts, are making a worthy contribution to a sane solution of medical service in a free society.

It is well to recall that CMS operates under a special act of the legislature which assures to our nonprofit voluntary corporation privileges that contribute to low overhead costs, including the provision that all members of the corporation, directors and officers, serve without compensation. This principle applies equally to lay and medical members, including the Professional Policy Committee. The act provides for supervision of contract and risk exposure in the public interest by the State Insurance Commissioner, an association that we have found most constructive and helpful. We have profited by the interest and advice so graciously given by the Commissioner and his staff.

Consistent with our new outlook the roster of officers, Board of Directors, Professional Policy Committee and administration is shown in this report as currently constituted. We are happy to welcome to this policy making group a number of new members who bring to our counsels wide experience in business and community affairs. We note with deep personal grief the death of Dr. Joseph H. Howard, able and sincerely devoted member, wise counsellor and friend.

The new Preferred Contract presents tangible results of advanced thinking with advantages of importance both to the medical practitioner and to the public. The quick appreciation, by enrolled groups or prospects, of its improved coverage is gratifying. With the approval of the Insurance Commissioner we shall continue our present Stand-

ard Contract, with the Preferred as an optional choice. We believe that we are advancing along constructive lines, with sufficient elasticity in Policy to adapt to desirable changing social concepts of medical practice as the future shall prove the need.

Independent operation has brought us into closer contact with our subscribing firms, with better understanding of their problems resulting in an improved and simplified billing procedure on group contracts, and other tangible benefits.

We are in process of setting up an arrangement with certain commercial banks and with the Mutual Savings Banks of Connecticut to make available to our direct-pay members a statewide network of points where payment of premium will be received.

We report with satisfaction the enlargement of our administrative group, with new employees trained and assigned, to form a well integrated organization with understanding of the job and with enthusiasm for the prospects of growth and service. We owe much to the intelligent guidance of our executive director and to the cadre of experienced department heads who have worked together under pressure to accomplish the transfer of functions and to assume so effectively, in so short a time, the complete servicing of our contract.

Four new members were elected to the Board: John Coolidge, of Hartford; J. Edison Doolittle and Carl G. Freese, of New Haven, and Dr. Thomas P. Murdock, of Meriden. Others re-elected include Mr. Judd, Dr. Creighton Barker, William B. Gumbart, Franklin R. Hoadley and Dr. Walter I. Russell, all of New Haven; Dr. Louis F. Middlebrook, of Hartford; Dr. Henry A. Archambault, of Norwich, and Dr. Thomas J. Danaher, of Torrington.

Mr. Judd and Dr. Middlebrook were re-elected president and secretary, respectively. Dr. Danaher was newly elected vice-president and Mr. Freese was newly elected treasurer.

Nominated to the CMS Professional Policy Committee, in addition to Dr. Danaher, who is chairman, and Drs. Archambault, Middlebrook and Russell, were Dr. William Curley, Jr., of Bridgeport; Dr. Thomas Feeney, Dr. Robert G. Reynolds and Dr. Edward H. Whalen, Jr., all of Hartford, and Dr. Orpheus J. Bizzozero, of Waterbury.

Dr. William H. Horton, executive director of CMS, told the Board that of the total claims paid,

While the problem of space for expansion had been faced and the matter of further separation of functions had been discussed in July, it was not until the first week of September, 1953 that final understanding for a completely independent operation was reached. We, as directors, give special commendation to Dr. William H. Horton and his immediate staff for their splendid accomplishment in organizing, procuring equipment, furnishings and files; designing billing forms, statements and stationery; setting up office routines and hiring and training people, to be ready to proceed with business at our new location beginning in December, 1953. All of this, fortunately, was possible in a new building ideal for our purpose, well located and of attractive design.

We believe strongly that experience has proven the worth of our service type of contract, in comparison with any indemnity coverage. On the present base of sound operation and a flexible policy, with the intelligent and practical support of the medical profession of Connecticut, we present to an enquiring public a convincing demonstration of a plan that can contribute to the maintenance of an effective free moving medical service with controls held at the local level.

53,300 were submitted by members of the plan who were within certain income limits and who qualified for Service Benefits. Under the CMS contract their doctors accepted the CMS payment as their full fee. Another 10,900 persons were over the income limits, but their doctors also accepted the CMS payment as their total fee. In all, 64 per cent of all the members who filed claims did not have to pay their doctors anything over the CMS benefit.

Dr. Horton also pointed out that another 109,000 members were added to the CMS rolls bringing the total membership up to the 700,000 mark. Another 153 doctors also signed Participating Physician agreements during the year, bringing that total to 2,143, or 85 per cent of all licensed physicians engaged in active practice in the State.

The Directors:  
HARTFORD

John Coolidge, 15 Diamond Glen Road, Farmington; President and Treasurer of Connecticut Manifold Forms Co.; President and Treasurer of the Colonial Empire, Inc. (Manchester); Treasurer of



the Manufacturers Association of Connecticut; President, Boy's Village in Milford; Secretary and Treasurer, West Hartford Manufacturers' Association.

Louis F. Middlebrook, Jr., M.D., 60 High Farms Road, West Hartford; Diplomate of the American Board of Obstetrics and Gynecology.

#### MERIDEN

Thomas P. Murdock, M.D., 19 Windsor Avenue, Meriden; Diplomate of the American Board of Internal Medicine; Fellow of the American College of Physicians; Trustee of the American Medical Association; Past President of the Connecticut State Medical Society; Past President of the New Haven County Medical Association.

#### NEW HAVEN

Creighton Barker, M.D., 119 Armory Street, Hamden; Executive Secretary, Connecticut State Medical Society; President, Federation of State Medical Boards of the U. S.

J. Edison Doolittle, 47 Commodore Place, Milford; Comptroller, The Southern New England Telephone Company; Vice-President, New Haven Taxpayers Research Council; Director, Tradesmens National Bank; Corporator and Director, Taylor Library, Milford.

Carl G. Freese, 67 Mill Rock Road, Hamden; President and Treasurer, Connecticut Savings Bank; Past President, National Association of Mutual Savings Banks; Past President, Savings Banks Association of Connecticut; Past President, New Haven Chamber of Commerce; Director, Security Insurance Company, First National Bank of New Haven, Grace-New Haven Hospital, Y. M. C. A., Boy's Club.

William B. Gumbart, 55 Laurel Road, Hamden; Attorney; Investment Analyst, First National Bank and Trust Company.

Franklin R. Hoadley, 114 Edgehill Road, Hamden; President, Farrel-Birmingham Company, Ansonia.

Robert S. Judd, 75 Old Farm Road, Hamden; Vice-President, Grace-New Haven Hospital.

Walter I. Russell, M.D., 139 Alston Avenue, New Haven; Past President, New Haven County Medical Association; Member of the House of Delegates of the Connecticut State Medical Society.

#### NORWICH

Henry A. Archambault, M.D., 2 North Second Street, Taftville; Fellow of the American College of Surgeons; Past President, New London County Medical Association; Member of the Council of the Connecticut State Medical Society.

#### TORRINGTON

Thomas J. Danaher, M.D., 445 Prospect Street, Torrington; Fellow, American College of Surgeons; Chief of Staff, Charlotte Hungerford Hospital; Past President, Connecticut State Medical Society; Delegate, The American Medical Association; Chairman of the Council of the Connecticut State Medical Society.

#### The Officers:

President: Mr. Judd.

Vice-President: Dr. Danaher.

Secretary: Dr. Middlebrook.

Treasurer: Mr. Freese.

The Professional Policy Committee—nominated by the Connecticut State Medical Society:

Thomas J. Danaher, M.D., Torrington, Chairman.

Henry A. Archambault, M.D., Norwich.

Orpheus J. Bizzozero, M.D., 290 Country Club Road, Waterbury.

William H. Curley, Jr., M.D., 82 Sport Hill Parkway, Easton.

Thomas Feeney, M.D., 4 Sunset Terrace, West Hartford.

Louis F. Middlebrook, M.D., Hartford.

Walter I. Russell, M.D., New Haven.

Edward J. Whalen, M.D., 41 Sedgewick Road, West Hartford.

## LETTERS TO THE EDITOR

### Treatment of Myopia

To the Editor:

February 3, 1954

Recently there appeared in the *Hartford Times*, and in other newspapers, a syndicated series of articles by Richard J. Apell, o.d., on nearsightedness and its treatment by exercises. As the author's conclusions were decidedly at variance with the prevailing ophthalmological opinion on the subject, I sent to the editor of the *Hartford Times* a letter presenting the ophthalmological thinking on this subject.

As I have been asked frequently—more so since the publication of the Apell articles—by physicians as well as lay people as to the merits of exercises in myopia, I am enclosing my letter to the editor of the *Times* for publication in the JOURNAL so that the medical profession in Connecticut may be made cognizant of the prevailing ophthalmological viewpoint on the subject of exercises in myopia.

Sincerely,

Dewey Katz, M.D.

To the Editor of *The Times*:

In view of some of the statements made by Richard J. Apell, o.d., in his recent series of articles on nearsightedness, which appeared in *The Times*, I would appreciate the opportunity of presenting some of the prevailing views of the ophthalmological profession as regards the problem of myopia—nearsightedness.

The causes of myopia are numerous and complex and determined by many variable components which, for the purpose of this communication, need not be discussed.

In the majority of cases, myopia is inherited and makes its appearance between the ages of five and puberty. It can be present and is present before five, and it can develop and does develop after puberty. Usually the greatest rate of increase in the progression of myopia occurs between the ages of 9 and 15.

The rate of progression lessens from the age of 15 to 23 and progressive myopia usually comes to a standstill of its own accord between the ages of 23 and 28. There can be and there are all sorts of variations from this normal pattern.

It is merely coincidental that in civilized countries intensive near work is begun and carried forward in

this age spread, for the near use of the eyes has little or nothing to do with the development or progression of myopia. Inheritance and growth factors play a much greater part than does environment and the use of the eyes.

These statements are conclusively proven by numerous facts. For example, progressive myopia follows the same pattern in the illiterate as it does in the literate.

The frequency of myopia is essentially the same in the industrial and cultured communities of the world as that among the Arabs who do no close work and live in wide open desert spaces.

It is significant that over 75 per cent of all people in all walks of life remain farsighted or have no refractive error, and that in spite of intensive near use of their eyes.

It is also significant that progressive myopia progresses more rapidly when the eyes are used much less intensively, that is from 9 to 15 years of age, and less rapidly when, comparatively, the eyes are used much more intensively, that is from 15 to 23 years of age.

It is most significant that after 23 years of age very few individuals develop myopia, and at this age level there is very little, if any, further progression of myopia in myopic individuals in spite of continued intensive use of their eyes, whether in the halls of learning or in factories or other fields of endeavor necessitating more or less constant near use of the eyes.

Every medical eye specialist has records of patients who are the exceptions to the rule, that is they have numerous patients in the age group from 5 to 23, who showed no progression of their myopia for a number of successive years and, in fact, a number of patients who showed a decrease in the degree of their myopia and this in spite of intensive use of their eyes and no "exercises."

Whether nearsightedness follows the normal pattern and increases, or is the exception to the rule and remains stationary or decreases in degree, the pattern which develops is not influenced by the use or lack of use of the eyes or by "exercises."

Seeing clearly requires more than the simple act of looking. Fixation, concentration, discrimination and interpretation are a few of the factors involved. These factors can be exercised.

Exercises will not obviate the need for glasses when there is a definite myopia present, not if clear distance vision is to be had and nature's physiologic optical laws are to be fulfilled, for the optical fac-



tors which result in the development of myopia cannot be changed at will by exercise.

In Baltimore in 1945, 103 selected myopic individuals were given intensive exercises for their myopia.

The participation of the Wilmer Eye Institute of the Johns Hopkins Medical School in this investigation was limited to examination of the patients before the beginning of the training and again after the training had been completed.

The Wilmer Institute, therefore, acted solely as a judge of the effect obtained. At the completion of this experiment the chairman of the Wilmer Eye Institute made a comprehensive report. The following is from this report.

"It was believed by the examiners that education in the correct interpretation of a blurred visual image was the chief factor in the improvement noted in this group.

"It was further believed that the exercises produced a beneficial psychological reaction in certain patients toward their visual handicap, regardless of whether an actual improvement in visual acuity had occurred.

"With the possible exception of educating some patients to interpret blurred retinal images more carefully and of convincing some others they could see better even though there was no actual improvement, this study indicates that the visual training used on these patients was of no value for the treatment of myopia."

Dewey Katz, M.D.

## Child Behavior Releases

To the Editor:

Regarding the treatment of strabismus and myopia by exercises, we should like it known that the articles appearing in a syndicated newspaper column called "Child Behavior" and coming from the Gesell Institute of Child Development represent the views of this institute.

The Gesell Institute is a private organization located in New Haven, Connecticut with no connection with Yale University or its Section of Ophthalmology.

Very truly yours,

R. M. Fasanella, M.D., and staff  
(Chief, Section of Ophthalmology)

## International Travel and Health Protection

A revised International Certificate of Inoculation and Vaccination approved by the World Health Organization and the Pan American Sanitary Organization has been issued by the United States Department of Health, Education, and Welfare. This is the only type of immunization document accepted by many nations, with the old form remaining valid until the expiration date of recorded vaccinations.

The principal changes in the new certificate used for recording all immunizations received by a person travelling to a foreign country are as follows:—

(1) Smallpox and yellow fever vaccination certificates must have the approved stamp prescribed by the health administration of the country in which the vaccination is performed. In the United States, the stamp is that of the local or State Health Department of the area in which the immunizing physician practices, the Department of Defense, or a designated yellow fever vaccination center, or the seal of the Public Health Service. The signature of the Certifying Officer is no longer necessary.

a. The smallpox certificate become valid immediately on revaccination, and 8 days after the date of a successful primary vaccination.

b. The yellow fever vaccination certificate is now effective for 6 years instead of 4, and becomes valid 10 days after the date of vaccination (for India, Pakistan, and Ceylon 12 days) or if revaccinated within such period of 6 years, from the date of that revaccination.

(2) The International Certificate is written in both English and French.

Persons living in Hartford, or elsewhere, if immunized by a physician practicing in this city, may bring or send in their International Certificate to the Hartford Health Department, 488 Main Street for the approved stamp. In addition Hartford physicians may refer patients to the Health Department for the required vaccinations and families of service men residing in Hartford may avail themselves of this service without charge.

The new certificate costs \$2.50 per hundred and is obtainable from the following sources—Passport Agencies of the Department of State; Superintendent of Documents, United States Government Printing Office, Washington, D. C., and travel and air line agencies.

## OBITUARY

**Joseph Francis Jenovese**  
1907 - 1953

Joseph Francis Jenovese was born in Boswell, Pennsylvania, on June 28, 1907. He attended the University of Pennsylvania, receiving his B.A. degree in 1927 and his medical degree in 1930. Thus at the age of 23 he commenced his internship at Mercy Hospital in Pittsburg. After internship he spent five years in general practice in Ellwood City, Pennsylvania. From 1937 to 1940 he was a fellow in internal medicine at the Mayo Clinic where he completed a thesis on "The Role of Ascorbic Acid in Addison's Disease" for the degree of Master of Science in Medicine from the University of Minnesota. In 1940 he opened an office in Hartford for the practice of internal medicine as a specialty and was promptly appointed to the staff of the Hartford Hospital. In 1943 he entered military service in the medical corps of the Naval Reserve. He served at the Naval Hospital in Portsmouth, Virginia; the Marine Air Field at Cherry Point, North Carolina; the Naval Hospital in Bethesda, Maryland; and the Naval Hospital in San Diego, California. The last two of these assignments were in the field of psychiatry. In 1946, after his return to inactive duty with the rank of lieutenant commander, Dr. Jenovese resumed the

practice of internal medicine in Hartford. At this time he conducted the weekly medical clinics at the Hartford Hospital, and he inspired and helped to organize a medical office with four other physicians skilled in special fields of diagnosis. He hoped that this group might function as a unit, but this aspiration was never fulfilled. In 1947 he learned of the malignant nature of the recurrent lymphadenopathy which he had experienced for the previous four years. With this knowledge it seemed wise to continue in individual practice. He left after his death on November 24, 1953 a host of patients who had been helped by his meticulous studies and inspired by his courageous, genial, and reassuring personality. His buoyant, friendly manner gave no sign even to his most intimate friends that he was harboring a fatal illness.

Dr. Jenovese's professional life was devoted to improvement in the practice of diagnostic medicine. He had learned from such men as Alfred Stengel, David Riesman, and O. H. Perry Pepper that good diagnostic work depended primarily upon keen observation during history taking and on examination of the patient. At the closed staff Mercy Hospital in Pittsburgh he had noted the important contributions which trained internists were making in the care of patients on the surgical services. His years of general practice in Ellwood City demonstrated to him the handicap imposed by constant interruptions. During his years at the Mayo Clinic he came to recognize the importance of teamwork in diagnosis. However, he deplored the trend toward impersonal diagnostic clinics operated by hospitals and other institutions, believing that the medical profession itself should assume the responsibility for comprehensive diagnostic service within the framework of private practice. He shunned opportunism. His goals and his principles were constant, and he adhered to them tenaciously without regard to popularity or personal reward. His skill was recognized by a large number of physicians in northern Connecticut, and he had an extensive consulting practice.

At the time of his death Dr. Jenovese was an associate physician at the Hartford Hospital and the Veterans Home and Hospital in Rocky Hill. He



was a consultant in internal medicine to the Manchester Memorial Hospital and the Johnson Memorial Hospital in Stafford Springs. He belonged to the American Medical Association, the Connecticut State Medical Society, the Hartford County Medical Association, and the Hartford Medical Society, of which he was secretary and chairman of the program committee at the time of his death. He was a fellow of the American College of Physicians.

Dr. Jenovese was married in 1931 to Anne Carabillo of Hartford; their daughter, Anne Lee, was born in 1942.

Dr. Jenovese was a skilled internist, a man who adhered rigidly to his meticulous standards and who faced his final illness with inspiring courage. In his death the medical profession has lost one whose high ideals have set a standard for others to develop and whose influence will long be felt in Hartford and the surrounding counties.

Benjamin V. White, M.D.

### Manuscript Editing Service

The American Medical Writers Association Editing Service is coming to be used at an increasing rate. The mechanics of the service is simple. The paper is sent to Harold Swanberg, M.D., W.C.U. Building, Quincy, Illinois, with a request that it be subjected to the editing service. The cost is small—\$4 for 1,000 words or less and \$3 for each additional 1,000 words or fraction thereof. The service is available to anyone but the cost to nonmembers is 50 per cent greater than the amounts shown above.

### New Bank Payment Method for CMS Subscribers

The 75,000 nongroup subscribers of Connecticut Medical Service now have a choice of two methods for paying their quarterly CMS dues. Through the cooperation of 40 banks and their 28 branches CMS Individual Pay members now have a total of 67 points throughout the State at which they can pay their CMS dues, if they prefer this method to mailing their payments to the CMS General Offices at New Haven.

Participating in the program are the 14 branches of the Hartford-Connecticut Trust Company; the

Colonial Trust Company of Waterbury and its three branches, as well as 37 Mutual Savings Banks and their 11 branches.

### New Project to Aid Medical Education Organized in California

National distribution of a new means of communication for medical learning has been undertaken by the California Medical Association through its recently formed, nonprofit subsidiary, Audio-Digest Foundation.

Using tape recorded material, the Foundation makes available to doctors everywhere three "post-graduate services" designed to save their time while increasing the scope of their practice-useful knowledge.

The basic service is the weekly issuance of a one hour tape for general practitioners, on which are recorded from 20 to 30 abstracts of the best in current medical literature embracing all fields. These articles are screened by a board of medical editors of which Edward C. Rosenow, Jr., M.D., Pasadena, is editor in chief. As a corollary service, Audio-Digest offers semi-monthly digests in the fields of surgery, internal medicine and OB-Gyn. The third service is tape-recorded lectures and panel discussions on one hour reels for individual or group purchase. Many of these lectures are illustrated by film strips made from the speaker's own slides and cued by him in the recording.

"One of the most appealing factors about these services," Dr. Rosenow said, "is that they are of definite, practical value to the physician. Much of the literature digested would not ordinarily come to the busy practitioner's attention. And the advantages of hearing world renowned authorities in medicine and surgery at your own hospital staff meetings or in your own living room are obvious."

Dr. Rosenow added that reserve funds accruing from the distribution of these tapes are specifically earmarked by the California Medical Association for distribution among the nation's medical schools, possibly through the AMA's National Education Foundation.

Headquarters offices for Audio-Digest Foundation are at 800 North Glendale Avenue, Glendale, California. Mr. Jerry L. Pettis is executive vice-president.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. Dewey Katz, Hartford  
*President-Elect*, Mrs. Newell W. Giles, Darien  
*Second Vice-President*, Mrs. Winfield Kelly, Norwich

*Recording Secretary*, Mrs. Walter Nelson, Cromwell  
*Corresponding Secretary*, Mrs. Stevens J. Martin, Hartford  
*Treasurer*, Mrs. Norman J. Barker, Collinsville

### Medical Art Exhibition

The Medical Art Exhibition will be held at the Bulkeley High School in Hartford on April 28, 29 and 30. It is open to physicians, their wives and families. Members are urged to contact their auxiliary art chairman now for information about the exhibit. The Auxiliary has had a fine record to date for winning awards in this show.

### 1953 Conference Highlight

By order of the Board of Directors and with the approval of the American Medical Association, the Woman's Auxiliary will accept the invitation to membership from the National Citizens Committee for Educational TV. It is hoped this contact will serve as an additional outlet for the health educational program of the Auxiliary.

### Civil Defense

Civil Defense chairman, Mrs. Hill, attended a Regional Civil Defense meeting in Simsbury during November. The keynote speaker was Mrs. Katherine C. Howard, deputy administrator of the Federal Civil Defense Administration, who stressed "Home Protection." There were panel discussions on "Disaster Living—Natural or War Caused," and "Civil Defense Training in Connecticut with Welfare, Health, Warden and Education Services." In early December there was another meeting in Hartford. At that time Dr. Edgar Prout, chief of Health Service, State Office of Civil Defense, discussed the implementation of the Civil Defense Medical Plan for the State. A plan has been set up whereby each of the five target areas: Bridgeport and Stamford, Hartford, New Haven, New London, and Waterbury will take care of all their own casualties.

### Public Relations

Public Relations chairman, Mrs. Bucciarelli, reported at the last Board of Directors meeting for the

State, that First Aid charts on which she has been working with Dr. Wakeman and his committee from the State Medical Society should be ready for distribution at the Rural Fairs late in the summer.

She discussed the Emergency Call Plan of the Connecticut State Medical Society which Mr. Burch expects to place in the various hospitals throughout the State for a week at a time. She will receive help from the Auxiliary to see that this exhibit is properly displayed and kept supplied with pamphlets.

### County News

#### HARTFORD COUNTY

Mrs. Asa Dion, Ways and Means chairman, announces that the profit from the benefit card party for the A.M.E.F. held at Centinel Hill Hall in January was \$460.42.

There was a legislative meeting in February at the home of Mrs. George Rosenbaum. Edward Langer of the National Fire Insurance Company spoke on "How Effective are Private Medical Insurance Plans."

#### MIDDLESEX COUNTY

On March 3 the Auxiliary met at Wesleyan University's Davison Art Center for a lecture tour of the building led by Professor Samuel Green. A tea at the home of Mrs. Benjamin Roccapiore followed.

Members headed a steering committee and participated in the Connecticut State Department of Mental Health's program of Christmas gifts for mental patients. They placed coin boxes and posters in public places and helped to transport and wrap gifts. A total of 7,560 gifts and \$1,834.74 were received at the Connecticut State Hospital.

#### NEW HAVEN COUNTY

Mrs. Walter Radowiecki of New Haven has been



appointed Ways and Means chairman to replace Mrs. Baer who has resigned. Her committee ran a fashion show in February at which time Mrs. Wakeman spoke on "American Medical Education."

On March 30 there will be a rummage sale.

The Annual Meeting has been changed to April 22.

Over 4,000 gifts were collected for patients in the Connecticut State Hospital at Christmas. Cash gifts of \$178 were given although the money was not solicited. Sixty dollars was given by the Waterbury Medical Auxiliary to be used for bus trips to take patients to see Christmas lights and decorations in Hartford. Sixty dollars was given by the Naugatuck Congregational Church to be applied toward the purchase of a television set for the patients. Meriden Auxiliary contributed \$12. The extra money was sent to the hospital for its Patients' Activity Fund.

#### NEW LONDON COUNTY

Mrs. Roger N. Fowler of Mystic has replaced Mrs. Martin O'Neil as chairman of the Art Committee.

#### WINDHAM COUNTY

Plans have been made for a benefit concert on May 8. Proceeds will go to the nursing scholarships. Carlo Lombardi, pianist, has offered to play for the benefit. Mrs. N. Dayton is in charge of tickets; Mrs. K. Kinney is in charge of publicity, to be assisted by Mrs. C. Garcina; Mrs. Rowson is handling the public relations.

This year the drive for Christmas gifts for Norwich State Hospital and Mansfield Training School was very successful. Over \$78 as well as 850 presents and five pounds of candy were forwarded to the patients. A console radio and console record player were given to the Norwich State Hospital.

### AUXILIARY ART-MUSICALE IN HARTFORD

The Connecticut Physicians Art group will hold its second art-musicale at the Avery Memorial in Hartford on Sunday, March 28. The program will include showing of the art exhibit from 5 to 6 P. M., cocktails 6 to 6:30 followed by a buffet supper, and a musicale by physicians and physicians' wives at 8 P. M.

Reservations will be limited to the first 200 applying and may be made through Mrs. David O'Keefe, 32 Sesson Avenue, Hartford at \$3.50 per person.

### Psychiatrists and Neurologists Meet

At a recent meeting of the Connecticut Society for Psychiatry and Neurology, the following officers were elected: President, Bernhard A. Rogowski, New Haven; Vice-President, Harold Wright, Greenwich; Secretary and Treasurer, Sidney Berman, West Haven; Councillors, Elias Marsh, Hartford and Ronald Kettle, Norwich.

A constitution was drafted for a Connecticut District Branch of the American Psychiatric Association.

The second meeting of the Society was held at Fairfield State Hospital on February 25, when Dr. Frederick Redlich spoke on "The Dynamics of Humor in Mental Disorders."

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## SPECIAL NOTICES

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

March 4

"Cholangiography"—Film and discussion

Charles Polivy, M.D., Harold Schwartz, M.D.

March 11

"Potassium Imbalance"

Robert R. Levin, M.D.

March 18

"The Aid to the Disabled Program"

Harold F. Pierce, M.D.

March 25

"Cortisone"—Film and discussion

Paul M. Sherwood, M.D., Julius J. Sachs, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut (Main Conference Room).

### FOURTH ANNUAL CARDIAC GRAND ROUNDS

Auditorium, Nurses' Home, St. Mary's Hospital, Waterbury, Conn., Thursday, April 1, 1954, 11:00 A. M.

Presented by the Cardiovascular Group of the Beth Israel Hospital, Boston.

1. Dr. Joseph E. F. Riseman

"The Management of Angina Pectoris"

2. Dr. Stanford Wessler

"The Medical Management of Peripheral Arterial Occlusive Diseases"

3. Dr. Paul M. Zoll

"Acute Myocardial Infarction and Its Treatment"

### G P MEETINGS

American Academy of General Practice Assembly  
Cleveland, Ohio

March 22-25, 1954

Massachusetts Academy of General Practice

Spring Clinical Assembly

New Bedford, Mass., April 7, 1954

The morning session at St. Luke's Hospital, beginning at 8:30, will feature medical films followed by a presentation by five members of the hospital staff. Subject to be announced.

Noon luncheon will be held at the New Bedford Hotel. The afternoon program will consist of a panel on the use

of cortisone and ACTH by the General Practitioner.

Dr. Chevalier L. Jackson of Temple University will discuss "What the Bronchoscope Can Do for the General Practitioner."

Massachusetts Academy of General Practice

Fall Clinical Assembly

Boston, September 22, 1954

### AMERICAN CONGRESS OF PHYSICAL MEDICINE

The Eastern Sectional Meeting of the American Congress of Physical Medicine will be held in Newark, New Jersey, Saturday, April 10, 1954. A tour of the Department of Physical Medicine and Rehabilitation of the recently opened Veterans' Hospital in Orange, New Jersey, is planned at 10:00 A. M. The afternoon session starting at 2:00 P. M. will be conducted at the Academy of Medicine in Newark, and following dinner at the Essex Hotel the evening session will consist of a panel discussion. Full program will be published when final plans have been completed. Chairman of the Section is Dr. Hans Behrend of New York City. Inquiries should be directed to Herman L. Rudolph, M.D., Section Secretary, 400 North Fifth Street, Reading, Pennsylvania.

### CANCER CYTOLOGY CONFERENCE

Dr. Joseph S. Stewart, Chairman of the Third Annual Seminar and Conference on Cancer Cytology to be conducted by the Cancer Institute at Miami, announces that the conference will be held on April 21-24, inclusive.

This year the conference will bring together several leading authorities on cancer from this country and abroad. The last day will be devoted to a special session for medical practitioners, who will visit the Cancer Institute to see demonstrations on the taking and preparation of cytodiagnostic tests for cancer of many types, with special sessions devoted to cancer of the uterus, breast, prostate, lung, and stomach. The latest advances in cancer diagnosis using new cytological methods and blood testing procedures will be presented.

Members of Dr. Stewart's Committee include: Dr. Virgil H. Moon, Honorary Chairman; Dr. Richard Fleming, Dr. Ralph W. Jack, and Dr. Milton Coplan. The program will be conducted under the direction of Dr. J. Ernest Ayre.

### THE AMERICAN GOITER ASSOCIATION

The 1954 meeting of the American Goiter Association will be held at the Somerset Hotel, Boston, Massachusetts, April 29, 30 and May 1, 1954.



The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

### 1954 INDUSTRIAL HEALTH CONFERENCE

Hotel Sherman, Chicago, Illinois, April 24 to 30, 1954

April 26-30—Industrial Medical Association

April 25-27—American Conference of Governmental Industrial Hygienists

April 26-29—American Industrial Hygiene Association

April 27-29—American Association of Industrial Dentists

April 26-30—American Association of Industrial Nurses, Inc.

April 24-30—U. S. Navy I. H. Organization

Registration fee \$3

### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The Directors of the American Board of Obstetrics and Gynecology wish to express their thanks to the following gentlemen who responded so willingly to the request for help in proctoring the recent written examinations on Friday, February 5, 1954.

Maurice I. Bakunin, Bridgeport, Howard S. Morrow, Danbury, and Lewis P. James, Hartford.

The next scheduled examinations, Part II (oral and pathological), for all candidates will be held at the Edgewater Beach Hotel, Chicago, Illinois, May 10 to 17, 1954. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examinations.

### CHEST DISEASE SYMPOSIUM FOR GP'S IN SARANAC LAKE THIS SUMMER

The third annual Symposium on Tuberculosis and Other Chronic Pulmonary Diseases for General Practitioners will be held in Saranac Lake, New York from July 12 through 16, 1954. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the American Trudeau Society, the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is \$40 for A.A.G.P. members and \$50 for non members.

The scope of this year's Symposium has been broadened to cover chest diseases other than tuberculosis. Included in the course will be discussions of the diagnosis and treatment of nontuberculous pneumonias, pulmonary cancer, lung abscess, fungus diseases, bronchiectasis, sarcoid, cystic disease, emphysema, and the pneumoconioses.

The speakers and panel members at the Symposium will include thirty-four physicians, surgeons, and scientists from Saranac Lake and surrounding areas. Guest lecturers include Dr. D. Ewan Cameron, Professor of Psychiatry, Mc-

Gill University, Montreal, and Dr. Donald Miller, Assistant Professor of Thoracic Surgery, University of Vermont Medical School, Burlington, Vermont.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M.D., Chest Disease Symposium, P. O. Box 2, Saranac Lake, New York.

### INTERNATIONAL CONGRESS OF OBSTETRICS AND GYNECOLOGY

Geneva, Switzerland, July 26-31, 1954

Copies of Information Bulletin about the Congress may be obtained upon request from World-Wide Travel Service Corporation, 2311 Calvert Street, N. W., Washington, 8, D. C.

### INTERNATIONAL CONGRESS OF INTERNAL MEDICINE

Stockholm, Sweden, September 15-18, 1954

The Third International Congress of Internal Medicine will be held in Stockholm September 15-18, 1954 under the auspices of the International Society of Internal Medicine in which forty nations are represented. The program for the Congress includes two symposiums, one dealing with hypertension, its pathogenesis and treatment, and the other with collagen diseases. Several American internal medicine specialists will be among the principal speakers. In addition, papers will be presented on such subjects as heart diseases, endocrine disturbances, gastrointestinal diseases, and diseases of the blood and liver. The meetings will be held in the Stockholm Concert Hall. Visits will be made to hospitals and scientific institutions. The Congress Committee in Stockholm is headed by Professor Nanna Svartz, of the Caroline Medical Institute, who is president of the International Society of Internal Medicine.

### W.M.A. PLANS TOURS IN CONNECTION WITH ASSEMBLY

The World Medical Association, through the Rounds Travel Service, Inc., 52 Vanderbilt Avenue, New York, has announced several suggested tours and itineraries in conjunction with the Eighth General Assembly in Rome, September 26 through October 2.

In addition to the main itinerary covering the above dates and selling as low as \$145 for the land arrangements, Rounds Travel Service also has prepared a choice of eight pre-convention and postconvention itineraries covering all countries on the Continent.

Tour brochures will soon be mailed to all members of the U. S. Committee of the World Medical Association. The suggested tours are listed, but the travel service is equipped and prepared to handle all transportation needs and to prepare any type of itinerary desired.

Since vacation travel is expected to be heavy during the coming year, the travel agency suggests that early arrangements be made.

PAN-PACIFIC ASSOCIATION SIXTH CONGRESS  
Honolulu, Hawaii, October 7-18, 1954

Doctors are cordially invited to attend the Sixth Congress of the Pan-Pacific Surgical Association to be held in Honolulu, October 7-8, 1954, and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program with over 100 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

The Association office has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information, please write to F. J. Pinkerton, M.D., Director General, Pan-Pacific Surgical Association, Suite Seven, Young Building, Honolulu, Hawaii.

OUR NEIGHBORS

New Jersey

With Hill-Burton aid New Jersey has outlined a construction program which will result in 10,246 additional beds by 1960. As of November 30, 1953, 44 construction projects were being planned but had not been reduced to applications. At the same time there were 30 projects on which either plans or application for grants-in-aid had been received and 17 projects under construction. The total cost of these 77 anticipated new construction projects is expected to approach \$100 million.

NEWS  
from County Associations

Fairfield

Karl Harpuder, assistant clinical professor of medicine at Columbia University and attending physician of physical medicine and chief of the Peripheral Vascular Diseases Section at the Montefiore Hospital in New York, conducted a clinic in peripheral vascular diseases at St. Vincent's Hospital in Bridgeport on the afternoon of February 2. That evening Dr. Harpuder presented a paper to the

February meeting of the Bridgeport Medical Association at the auditorium in the Bridgeport Hospital Nurses Home.

Isaac L. Harshberger was elected to the presidency of the staff of Bridgeport Hospital at the January meeting of the staff. Other officers chosen were Nathan H. Friedman, vice-president and Joseph J. Esposito, secretary.

According to the *Bridgeport Post*, William Kaufman of Bridgeport has been invited to address the Third International Gerontological Congress at London, July 19 to 23, on "Reversal of Some Phenomena of Aging by Vitamin Therapy," and "Psychosomatic Problems in Older People—the Fallacy of the Single Cause."

From London Dr. Kaufman goes to Zurich to read a paper on "Management of the Transference Relationship in the Psychotherapy of Patients with Food Allergy" before the International Congress for Psychotherapy.

Dr. Kaufman also read a paper in December before the American Psychiatric Association at the AAAS meetings in Boston, entitled "Some Emotional Uses of Money."

Hartford

A new poster giving medical tips for the traveler was on display in January at the Times Travel Show. HCMA handed out information slips with advice on shots, food and medical aid when traveling in Europe. Approximately 15,000 saw the show.

Mt. Sinai announced in January the following changes on the medical-surgical staff: consulting staff appointment: Carl L. Thenebe, pediatrician; attending staff: Henry M. Glaubman, pediatrician; Benjamin H. Gottesfeld, neuropsychiatry. Assistant staff Jack Gurwitz and Nathan M. Winick, surgery; Joseph Kaschmann, medicine; David Robinson, obstetrics and gynecology; and Irwin T. Mancall, ophthalmology. Clinical assistant staff: Morton Opinsky, Harold Lipton, Daniel Marshall, Harold Schwartz, Philip T. Goldenberg, and Marvin H. Grody.

The following physicians were appointed to various medical staffs of the Veterans' Home and Hospital, Rocky Hill: John C. Leonard, Edward Nichols, Edward Martin, internal medicine; Edward J. Whalen, otolaryngology; Benedict B. Landry, Philip G. McLellan and Welles A. Standish, surgery; Salo J. Silbermann, neurosurgeon; Henry L. Birge



and Louis D. Harris, attending ophthalmologists; Anthony V. Nevulis, Charles W. Goff, Gerald S. Greene, Walter F. Jennings, Frank S. Jones, and J. Whitfield Larrabee, senior attending orthopedists.

Hugo D. Angelini, Timothy L. Curran, Edward H. Truex, Jr., Charles A. Tucker, and Morris M. Mancoll, otolaryngology. Eugene R. Studenski, senior pathologist; Samuel A. Schuyler, senior physical medicine and rehabilitation; Charles I. Solomon and Isidore Schnap, senior attending psychiatrists; Miriam Liberson, chief of radiology; Stanley J. Motyka and Edward C. Porter, senior attending radiologists. Edward L. Besser, Burwell Dodd, Nicholas A. Mastronarde, Donald R. Morrison, N. William Wawro and Chester A. Wiese, senior attending physicians in surgery.

The new officers for 1954 of the Manchester Memorial Hospital medical staff are: A. Elmer Diskan, president; Jacob A. Segal, vice-president, and Joseph C. Barry, secretary.

New president of the New Britain Medical Society is Sidney E. Eisenberg. Harry A. Parlato is vice-president and secretary is Vincent J. Squillacote.

As part of a community program the Institute of Living's Francis J. Braceland, John Donnelly, and John I. Nurnberger spoke in a series of five free public lectures on mental health recently.

William Champion Deming died in Litchfield on January 16 at the venerable age of 91. Dr. Deming had spent most of his life in either Litchfield or Hartford Counties. Following World War I while serving full time with the Veterans Administration in Hartford and later in Newington his familiar figure was often seen on the streets of Hartford taking his constitutional. He was a great lover of the outdoors and an expert on nuts.

### Litchfield

The mid winter meeting of the Litchfield County Medical Association was held at the Conley Inn, Torrington, on Tuesday, January 26. Sixty members and guests attended. Major John Cavanaugh of Westover Airfield gave a most enlightening and interesting talk on "The Problems in Aviation Medicine." Following the dinner and Major Cavanaugh's talk, the regular business meeting was held.

New members elected to the Association were John Britton Irwin, and Howard Sheffield Jeck, Jr., both of Torrington.

The obituary of the death of Dr. Gilbert Hubert, pediatrician of Torrington, was read by Dr. Francis A. Sutherland.

### Middlesex

Carl Chase attended a course on "Glaucoma and the Use of the Slit Lamp" which was given at the Brooklyn Eye and Ear Hospital recently.

James M. Cary has been certified as a specialist by the American Board of Orthopedic Surgery. He received his specialty training at the Newington Home for Crippled Children, the New Haven Hospital and the Hartford Hospital. He is associated in practice with Fred Sweet.

Milo Rindge, health officer and practising physician in Madison for 47 years, died on January 19 at the age of 82. Dr. Rindge was a past president of the New Haven County Medical Association and the New Haven County Public Health Association.

### New Haven

At the annual meeting of the Connecticut Board of Surgeons, Incorporated, L. N. Claiborn of New Haven was elected president by the Executive Committee and Al Hurwitz, chief of surgery at the Veteran's Hospital in West Haven, was reelected secretary-treasurer of the Society.

On February 3 at the New Haven Medical Association C. Stuart Welch, Department of Surgery, Albany Medical College, Albany Hospital, spoke to the Society on the subject of "Portal Hypertension."

On March 3 Dr. Paul B. Beeson, professor of medicine, Yale University, will be the speaker of the evening.

On February 2 at the Griffin Hospital Clarence Schein of the Montefiore Hospital spoke to the Griffin Hospital staff on the subject of "Diseases of the Esophagus."

The Griffin Hospital on February 1 adopted new by-laws and a complete reorganization of the staff was voted in by the Griffin Hospital staff, the executive committee of the hospital, the board of directors, and the joint conference committee.

# Clinical Results\* with Banthine® Bromide

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## 22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications†	Side Effects Requiring Discontinuance of Drug‡	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6‡			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiasen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34‡				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6‡			18			
Maier, Meili	38	38	24			14‡	27	7	4‡				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49‡	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42‡									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4‡	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

“Good” relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

“Complete” evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was “good” or “fair.” In all but 22.9 per cent, evidence of healing was “complete” or “moderate.”

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



\*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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## New London

The monthly dinner lecture meeting of the Lawrence and Memorial Associated Hospitals was held Thursday, January 21. The speaker was John F. Sullivan, associate professor of neurology, Tufts College Medical School, and chief of neurology of the New England Center Hospital. His subject was "Recent Advances in Prevention and Pathophysiology of Poliomyelitis"

There was a special joint meeting of the New London County Medical Association and dentists of New London County, Thursday, January 28, at Lighthouse Inn. The speaker was Melvin F. White, M.D., D.M.D., instructor plastic surgery at Harvard Medical School; chief plastic surgeon, New England Medical Center, Boston City Hospital. His topic was: "Plastic Surgery." The affair was well attended and plans for future joint meetings were discussed.

Ellen F. Birchall, M.D. announces the opening of her office for the practice of psychiatry and neurology at 435 Montauk Avenue, New London.

The regular monthly meeting of the New London County Medical Association was held Thursday, February 4 at the U. S. Coast Guard Academy. The speaker, Franz Ingelfinger, professor of gastroenterology at Boston University, attending physician, Massachusetts Memorial Hospital, spoke on "Diverticulitis." An informal dinner at the Mohican Hotel preceded the meeting.

Anulf VanDyk of 50 Granite Street, New London, has recently received word that he passed the examination for American Board in Orthopedic Surgery.

On February 2 Donald Shedd, instructor in surgery at Yale University, spoke to the staff of the Lawrence and Memorial Hospital on "The Management of Patients with Head and Neck Carcinoma."

The New London Chapter of the Connecticut Heart Association had William Glenn, associate professor of surgery, Yale University, as guest speaker on February 11 at the Lawrence and Memorial Hospital. Dr. Glenn spoke on the recent advances in cardiac surgery. Movies and slides were shown.

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## Connecticut at Medical Education Congress

At the Fiftieth Annual Congress on Medical Education and Licensure of the AMA held in Chicago in February, John C. Leonard, director of medical education at the Hartford Hospital, addressed the panel of the Advisory Board for Medical Specialties on the subject "A Sound Program for Graduate Training in Non University Hospitals from the Hospital Viewpoint."

Vernon W. Lippard, dean of Yale University School of Medicine, was a member of a luncheon panel which discussed professional orientation.

Creighton Barker, secretary of the State Medical Society and secretary of the Connecticut State Medical Examining Board, reported on the first world conference on medical education held in London in August 1953.

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## NEW BOOKS IN REVIEW

*THE PSYCHIATRIST: HIS TRAINING AND DEVELOPMENT.* Report of the 1952 Conference on Psychiatric Education held at Cornell University, Ithaca, New York, June 19-25, 1952. Organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. Edited by John C. Whitehorn, M.D., Francis J. Braceland, M.D., Vernon W. Lip-pard, M.D., and William Malamud, M.D. Baltimore: Lord Baltimore Press. 1953. 214 pp. \$5.

Reviewed by JOHN DONNELLY

This report is the outcome of a conference on psychiatric education held in 1952 at Cornell University and represents the conclusions arrived at by leaders in the field of psychiatry currently engaged in the training of residents. Unlike most official reports the subject matter of the various commissions constituting the conference is presented in eminently readable form. While presenting the areas of general agreement, it offers also the minority opinions where differences are considered important.

The greatest advance in psychiatry in the past ten to fifteen years has undoubtedly been in the area of psychodynamics, and the longest section is appropriately devoted to this subject. Here, for the first time, is an attempt to set out the large areas in which there is considerable agreement among the different disciplines and to bring into clearer view the nature of major differences of opinion. The maturation of psychiatry can be seen in that the sibling rivalry between individual schools appears to be in the process of resolution on a more mature level than hitherto. No longer does any one school claim sole possession of the secret of the art. This chapter on psychodynamics is a remarkable piece of work, and if a synthesis of the hitherto divergent approaches is to be effected, this may well be held to be the beginning.

Special chapters are devoted to aspects of residency training, including the selection of the nascent psychiatrist—and his selection of psychiatry—the personal problems and difficulties of the psychiatrist in training, and the establishment of ideal training programs and teaching methods. Many of the conclusions are of significance. For example, comparable to the failure of attempts during war-time to select, by psychological tools, men with special aptitudes and qualities for specific tasks, such as Air Force pilots, is the conclusion that there is no single method or group of methods entirely satisfactory in the selection of able psychiatrists. The whole technique of evaluation of longitudinal life history still stands the test of time—with least value placed on letters of recommendation. Emphasis is placed on the growth in experience which may occur in residents and on the great personal benefits which many derive from their association with the field.

But perhaps the section that will be most intently read is that on the role of psychoanalysis. Considerable changes in outlook are occurring as the heat of battle of the past few decades dies down. That psychoanalysis must occupy

a prominent place is without question, especially for those desirous of practicing as psychoanalysts and for those who may be helped by a personal analysis. Nevertheless, the emphasis appears to be placed on the principle, "It is not necessary to be psychoanalyzed in order to develop confidence as a psychiatrist, including competence in psychotherapy and psychodynamics." This movement to bring psychoanalysis into perspective in the training of residents will advance the practice of psychiatry as a whole further than all the struggles of the past thirty years. It is to be noted that the commission included some well known psychoanalysts.

Attention is also directed to the special fields including administrative, forensic, industrial, psychosomatic, and military branches. Moreover, the role of psychiatry in the training of other medical specialists is examined and emphasis is placed on the benefits which may be obtained by the incorporation of the teaching of psychiatric principles in the various specialist-training programs. The extension of psychiatry into other areas, both medical and non medical, has been hastened by the recognition of the importance of the modern holistic approach to illness and health.

This volume is to be highly recommended, not only to those training psychiatrists and to psychiatrists in training, but also to all doctors in whatever field they may be practicing. In this book there is at least one section which is of significance to every physician.

*SCHOOL HEALTH SERVICES.* By Charles C. Wilson, M.D., Professor of Education and Public Health, Yale University, Editor *National Education Association of U.S. and American Medical Assoc.* 1953. 486 pp. \$5.

Reviewed by LEONARD PARENTE

Much has been written on school health and many phases have been studied by various agencies and committees interested in school health. "School Health Services" was prepared by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, under the direction of Charles C. Wilson, M.D., and a noteworthy contribution has been made. This book is a companion book of "Health Education" which was also a publication of the Joint Committee.

There are 18 chapters, dealing with health services and related school health functions. Each chapter was prepared by an expert in that particular subject of school health and in turn this material was further reviewed by a consultant. The book, therefore, is not the opinion of one author but a composite view of many experts in the field of school health. Every health service is discussed separately and in dealing with controversial aspects of school health services there is no hesitation on the part of the editors to admit this fact and point out where more research is needed.

Although the subject matter deals mostly with the area of school health services, other areas such as sanitation and health education are also touched on, for they are definitely related to the subject of health services within a school.

This book should be of value not only to school administrators but to all persons concerned with supplying health

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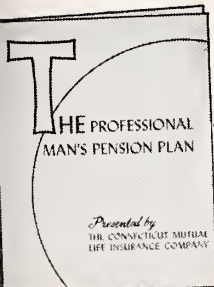
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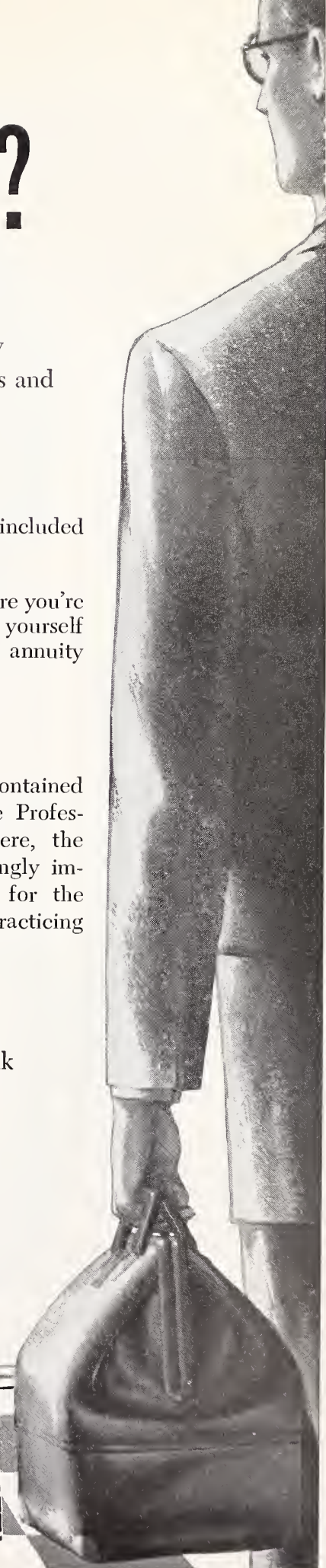


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services in the schools. These include physicians, dentists, nurses, dental hygienists, psychologists, social workers, health educators, physical educators and teachers. It is an excellent text for the school physician or school medical advisor, in that it orients him to his contribution of medical services to the school health program as a whole. The book dispels the idea which some physicians might hold, namely, that school health services consist principally of physical examinations of school children. It clearly brings out the fact that a complete health appraisal of the school child must take into consideration all the services enumerated in the various chapters.

"School Health Services" also points out the health responsibilities of the school along with the modern concept of education which demands that the school concern itself with discovering and providing solutions to children's needs. It further demonstrates the need for coordination of the school's health program and the school's effort with that of the community, the health department, the private physician and dentist, and the other community health and social agencies.

There is much material in this volume that can be used for the improvement of school health services, whether it be in a small school system or a large one. There is a splendid bibliography and there is also a carefully prepared index so that subject matter in the text can be quickly found. This book should find its place in the libraries of all persons concerned with school health.

*PHYSIOLOGY OF THE EYE, CLINICAL APPLICATION.* (Second Edition.) By Francis Heed Adler, M.A., M.D., F.A.C.S. Philadelphia: The C. V. Mosby Company. 1953. 734 pp. 329 illustrations. \$13.

Reviewed by ARTHUR M. YUDKIN

Dr. Francis Heed Adler, a recognized authority in ophthalmology and human physiology, has written a book which offers to the student and practicing ophthalmologist the most recent findings of the physiology of the eye. The experimental laboratory observations and clinical application are utilized wherever possible. His understanding of clinical manifestation of disease, together with his research in physiology, is reflected in every chapter of *Physiology of the Eye*.

The interpretation of the ocular circulation in health and disease is excellent. In man all of the blood reaches the eye by way of the internal carotid artery. The retinal vascular dynamics which produce the arterial and venous pulsation are clearly described. References are made to the vasomotor tone and its regulation and its ultimate control of the eye. The role of the sympathetic nervous system in essential hypertension and its effectiveness on the ocular circulation are brought up to date and references for same are given. It is important to see how the ocular circulation may be involved with drugs used to alter the tonicity of the general circulation.

The subject of metabolism of the cornea is splendidly described in a language that can very easily be understood. The influence of various factors on corneal metabolism and the chemistry and metabolism in pathological conditions are discussed. The reaction to the corneal tissue by diseased

processes and subsequent vascularization of the cornea resulting from some of the diseases are fully presented. A study of the permeability of the cornea is offered for the student, the investigator, and the matured clinician. The subject of sensitivity of the body in general and of the cornea is an example of Adler's application of his early experience and interest in general physiology.

The theories concerning the formation and elimination of the intraocular fluid from the eye are presented in detail. This contribution should prove helpful in the study of glaucoma. The clinical interpretation of the variations of the intraocular pressure are based in part on laboratory findings. The character of the vasomotor nerves to the eye and the types of drugs which dilate or contract the intraocular vessels are discussed.

The anatomy and physiology of muscles in general are compared with the anatomical and physiological characteristics of ocular muscles. Much attention is given to the response of the ocular muscles to drugs. The medical and surgical approach to strabismus are given in detail. Under the caption of "Proprioception from Ocular Muscles" the investigation of Sherrington and Mott is recognized, and its possible application to the ocular muscles is considered. The nerve centers and pathways for voluntary movement are important to the function of the eye. The frontal centers for voluntary movements of the eye are listed and the course of the fibers from the frontal oculogyric centers to the pontile centers is described.

It is very interesting to have the author describe the nature and origin of light, its physical measurement, and its transmission by the ocular media. This chapter is followed by one on metabolism of the retina. It is concerned with the chemical and physical changes which constitute the metabolism of the whole retina and with the effect of light on visual processes. The subject of photochemistry has been modernized. An interesting evolutionary story of the pigment associated with photoreception is accomplished by referring to the work of Wald and others. Adler explains how the Grotthus-Draper Law of Photochemistry applies to photochemical reactions.

The legend of electrical phenomena in nerves is presented before describing the action potentials in the optic nerve fibers of man. The pros and cons of the value of action potentials developed in the retina are described under the heading of Electroretinograms.

A complete resume of the transmission of impulses from the retina to the occipital cortex is given in the chapter on visual pathways. Adler states that all physiologists are agreed that vision, as man experiences it, is a function of still higher parts of the brain, or perhaps of the brain as a whole. Psychological processes, such as visual percepts as contrasted with visual sensations, are so complex that they defy immediate physiological analyses; but continued study of the elementary physiological processes may eventually lead to a better understanding of the more complex phenomena.


The book lives up to its title, *The Physiology of the Eye and Clinical Application*. It is recommended to every physician for a better understanding of the functions of the eye and as a diagnostic aid to ocular and constitutional disorders.




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Reviewed by GILBERT W. HEUBLEIN

## PART I

### INTRODUCTION

The Diagnostic Section comprises 292 pages. Numerous articles have been reviewed. These range from the newer technical advances to x-ray diagnosis in head, spine and extremities, chest and finally the gastrointestinal and genitourinary systems. This volume is not only a necessity for the practicing radiologist, but will also be helpful to the medical specialist who is interested in various phases of roentgen diagnosis. The occasional subscripts provide worthwhile information in the form of constructive criticism, practical suggestions and important bibliographic data.

### SECTION ON TECHNIQUE

An important contribution in technique is the work of Pendergrass et al., in skin and depth doses of diagnostic roentgenology. Also the low cost, labor-saving punch card sorting of radiologic reports. The proper preparation of photographic prints is briefly discussed (Ollerenshaw).

### HEAD

In the Head Section an outstanding contribution is that of Etter who has done much to clarify our knowledge of the roentgen anatomy of the orbits. The importance of planigraphy of the temporal bone is stressed. There are numerous other reviews on posterior fossa dermoid cysts, cyclencephaly, tumors of the glomus jugularis and the use of angiography in the diagnosis of acoustic nerve tumors, etc. In regard to the radioactive dye—iodofluorescein—the authors make this comment:

"Preoperative localization of brain tumors using radioactive dyes and an external counter is of decidedly limited value when compared with the results obtained by ventriculography and angiography."

### SPINE AND EXTREMITIES

The section dealing with Spine and Extremities includes a pertinent review of some thirty-nine key articles. Normal variants of the cervical spine are discussed with reference to the usual mobility of the 2nd and 3rd cervical segments in children, not to be confused with subluxation.

Numerous other articles include summaries of osteitis condensans ilii, interpediculate measurements in children, Jaffe-Lichtenstein's disease; a discussion of the importance of full column technique in lumbar myelography;  $I^{131}$  myeloscintigrams, periostitis deformans, an interesting new entity recently described by Spanish authors; Ellis-van Creveld's disease, or chondroectodermal dysplasia; cortical defects with periosteal desmoids, aneurysmal bone cyst (Besse and Ghormley, et al) and finally the roentgen differentiation of Mönckeberg's from intimal atherosclerosis.

### CHEST

The Section on Chest is divided in two parts; there are thirty-three abstracts dealing with heart and great vessels. These have to do mainly with various forms of congenital heart disease and angiocardiology. Of especial interest

are the following: diagnosis of mitral valve disease (Kale et al, Univ. of Witwatersrand), systolic expansion of left auricle in mitral regurgitation (Elkin, Sosman, et al), syndrome of obliteration of the arterial branches of the aorta causing rib notching; the infundibular sign of patent ductus arteriosus. The indentation sign of Bruwer and Pugh, x-ray diagnosis of anomalous venous drainage, or the "collar sign" and pulmonary infarction resulting from cardiac catheterization.

The second part is of considerable general interest and reviews pulmonary disease in thirty abstracts: The roentgen signs of abnormal pulmonary function (Barden) are stressed. There are references to pulmonary disease in newborn and young children. These include comments on pulmonary "cysts," hyaline membrane disease, and the entity known as lobar emphysema. In adults there is consideration of the following: hidden bronchiectasis in the asthmatic patient, pulmonary edema in morphine addiction, or the syndrome of coma, pinpoint pupils and depressed respiration. So too, there are descriptions of pulmonary lesions in scleroderma, kerosene poisoning, berylliosis, the various pneumomycoses and cystic disease in sequestration of the lung.

### GASTROINTESTINAL SECTION

In the Gastrointestinal Section sixty-one articles are reviewed. These include among others discussion of dysphagia by contractile rings in the lower esophagus, gastric defects due to aberrant pancreatic tissue and lipoma, Crohn's disease of the stomach, the roentgen picture of the normal ileocecal valve (Hinkel), high voltage radiography as an aid in search for colonic polyps and massive fatal embolism from barium enema study. This section has several important abstracts dealing with splenoportography.

### GENITOURINARY SECTION

The Genitourinary Section includes twenty-four abstracts. We are impressed by such pertinent articles as "ice-water technique" for acceleration of delayed excretory urograms (Herzan and O'Brien), diagnostic kidney puncture (Lindblom), and several abstracts having to do with percutaneous retrograde iliac arteriography in gynecologic conditions. This section is worthwhile reading if only for the following editorial comment regarding the use of water-soluble, opaque media in hysterosalpinography.

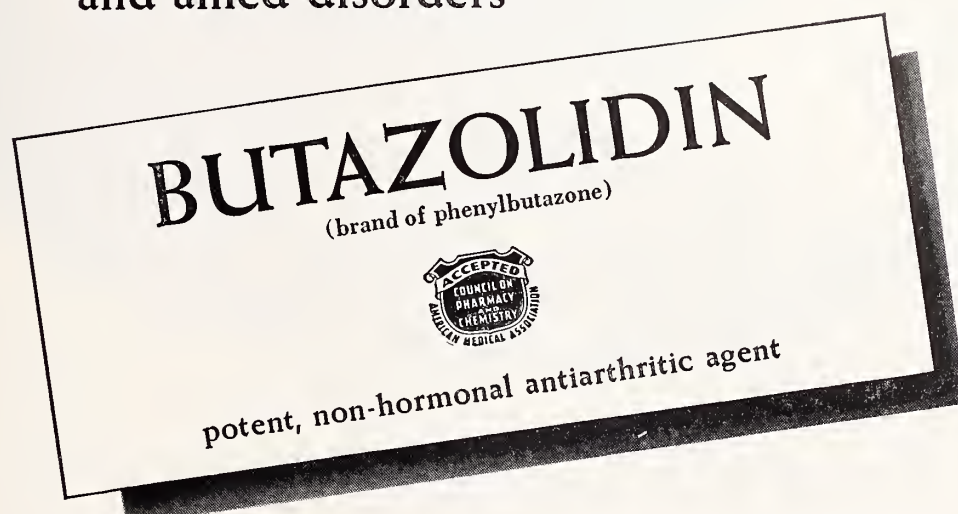
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## PART II

### SECTION ON RADIOTHERAPY, RADIOACTIVE ISOTOPES, PHYSICS AND RADIATION PROTECTION BY HAROLD W. JACOX AND VINCENT P. COLLINS

The section on radiotherapy (146 pp.) includes reviews of articles concerned with both malignant and benign conditions. Possibly reflecting the trend of the literature, there is a particularly large number of articles concerning the treatment of malignancies of the female genital tract. A large number of these articles were primarily statistical studies comparing various types of treatment. No particu-

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larly striking changes in the survival rates are recorded, although several of the more recent radiotherapeutic methods are said to have some promise. The rotational therapy of carcinoma of the esophagus carried out under fluoroscopic control by J. Frimann-Dahl in Oslo is reviewed and it is concluded that, despite good primary results and satisfactory palliation, the final results have been somewhat discouraging with all of the forty-one patients given treatments having succumbed to the disease after four years.

Great attention is paid to the use of radioactive gold in the treatment of pleural and peritoneal effusions as well as its employment in the interstitial irradiation of pelvic tumors. The editors make some significant notes on this treatment and suggest that some caution be employed in its application when this isotope is employed in the treatment of carcinoma of the prostate. The use of this isotope in the treatment of malignant effusions has apparently met with considerable success in reducing the necessity for frequent paracenteses.

The section concludes with a discussion of various research publications, a considerable number of which are concerned with the relative biologic effectiveness of super-voltage radiation as compared to the standard range of voltage employed for therapy. No particularly new conclusions are reached in this regard, although the previously known differences in skin effect are reiterated and the greater tolerance of the living organism for the higher quality of radiation is confirmed.

In general, this section of the book provides a comprehensive review of the field of radiotherapy during the year.

To summarize, there is another well illustrated and informative summary of radiologic literature covering the period between June 1952 and June 1953.

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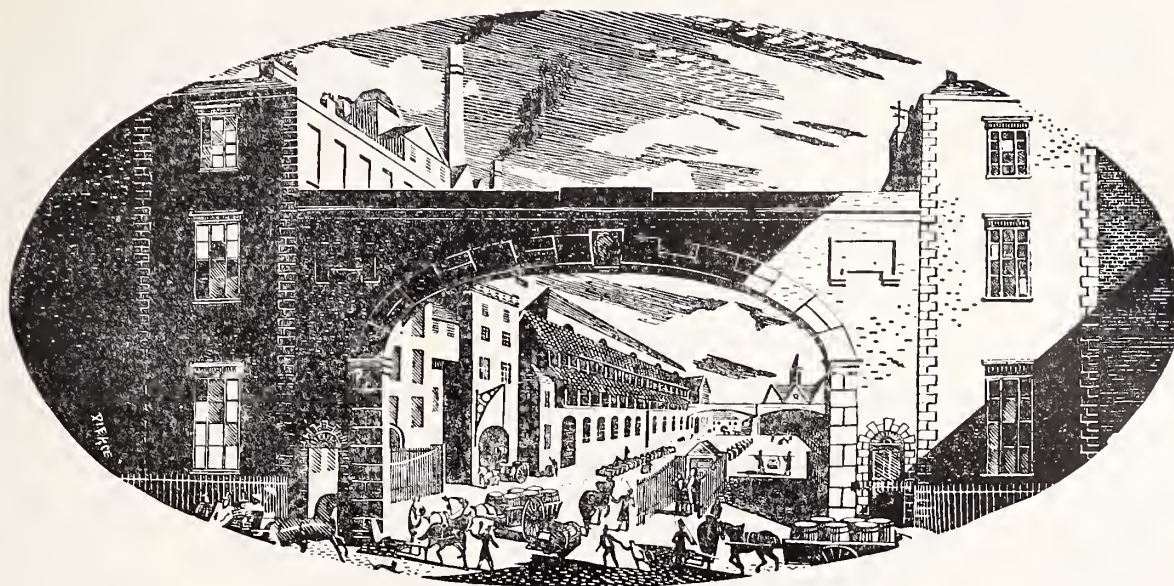
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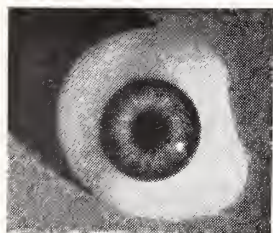
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"It is strange," Malleeson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.<sup>1</sup>

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."<sup>2</sup>

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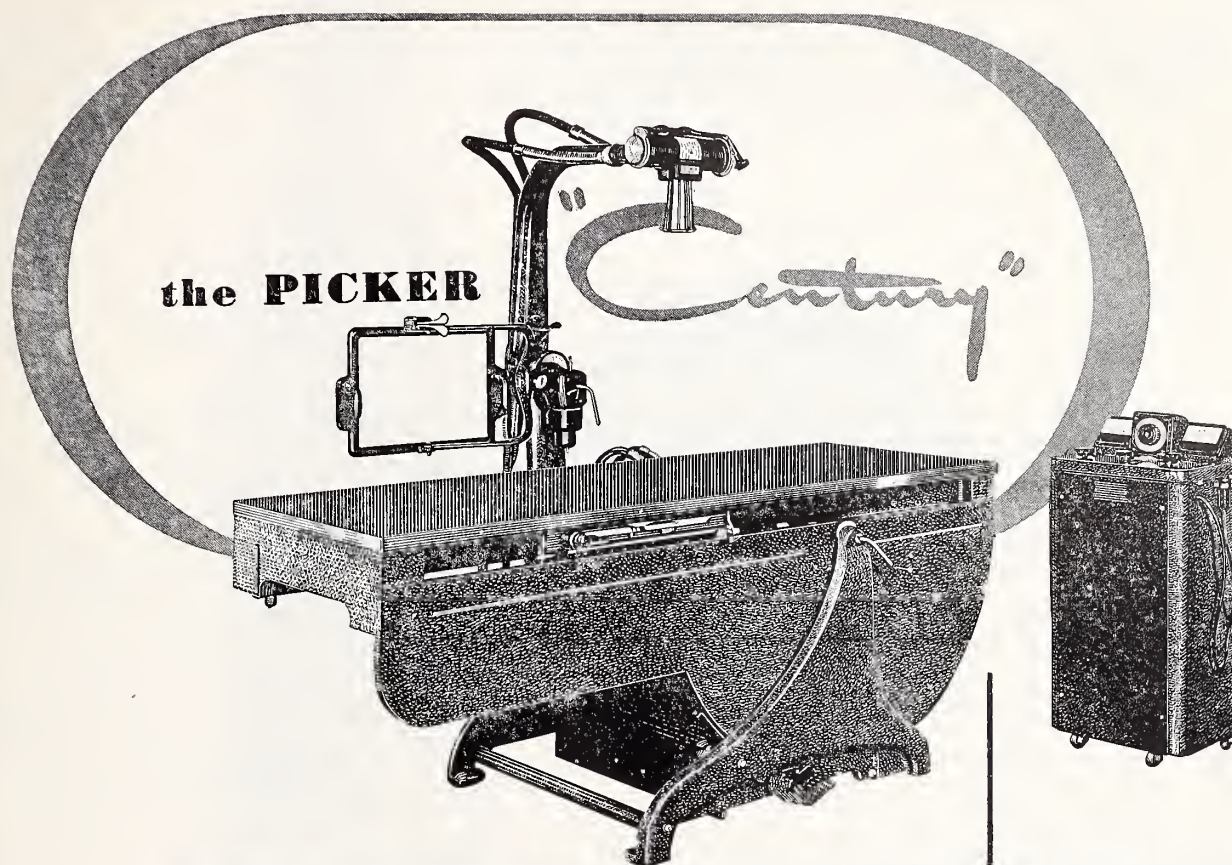
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1. Malleeson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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# **NATIONAL HEALTH WEEK**

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# The Connecticut State Medical Journal

EDITORIAL AND BUSINESS OFFICE, 160 ST. RONAN STREET, NEW HAVEN, CONNECTICUT

*Editor-in-Chief*

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Footnotes, bibliographies and legends should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodicals with volume, page, month—day of month if weekly—and year.

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OTHER COMMITTEES OF THE SOCIETY ARE APPOINTED BY THE COUNCIL





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The old Melodeon building, formerly the Fourth Congregational Church, stood on the west side of Main Street midway between Christ Church and Pratt Street.

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of Photographs of Old Hartford  
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THE MISSES TAYLOR*

# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVIII

APRIL, 1954

No. 4

162nd ANNUAL MEETING  
of the  
Connecticut State Medical Society  
BULKELEY HIGH SCHOOL, HARTFORD  
April 27, 28, 29, 1954

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PROGRAM COMMITTEE

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SAMUEL D. KUSHLAN, *New Haven*

WALTER WEISSENBORN, *Hartford*

LOCAL COMMITTEE ON ARRANGEMENTS

STEWART P. SEIGLE, *Hartford, Chairman*

SIDNEY L. CRAMER, *Hartford*

JAMES S. MISSETT, *Hartford*

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## P R O G R A M

Tuesday, April 27

ANNUAL MEETING OF THE HOUSE OF DELEGATES

AUDITORIUM

COLE B. GIBSON, *Meriden, Speaker of the House, presiding*

10:00 CALL TO ORDER  
BUSINESS SESSION

1:00 Luncheon for Officers, Members of the House, and Guests

2:00 Resumption of business

7:00 ANNUAL DINNER OF THE COUNCIL—The Council will hold its annual dinner for the Program Committee, the Local Committee on Arrangements, and guests, at the Tumble Brook Country Club, Bloomfield



Wednesday, April 28

AUDITORIUM

9:00 REGISTRATION—Exhibit Hall

9:15 MOTION PICTURE FILM

9:30 CALL TO ORDER—President of the Society

ADDRESS OF WELCOME—President of the Hartford County Medical Association

H. M. MARVIN, *New Haven, presiding*

10:00 MEDICAL MANGEMENT OF HYPERTENSION

Henry A. Schroeder, *St. Louis, Missouri; Associate Professor of Medicine, Washington University School of Medicine, St. Louis; Assistant Physician, Barnes Hospital, St. Louis; Director of Hypertension Division, Department of Internal Medicine, Washington University School of Medicine*

10:35 THE DIAGNOSTIC APPROACH TO DISEASES OF THE LUNGS

Edward J. Welch, *Brookline, Massachusetts; Instructor in Medicine, Boston University School of Medicine; Assistant Chief of Staff, Channing Home for Pulmonary Tuberculosis, Boston*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

RALPH E. KENDALL, *Hartford, presiding*

11:40 NO ANATOMIC CAUSE OF DEATH—THE ENIGMA OF THE FORENSIC PATHOLOGIST

Lester Adelson, *Cleveland, Ohio; Assistant Professor of Legal Medicine, Department of Pathology, Western Reserve School of Medicine, Cleveland, Ohio; Pathologist and Chief Deputy Coroner, Cuyahoga County Coroner's Office, Cleveland, Ohio*

12:20 RADIOACTIVE ISOTOPES: PRESENT USES AND SOME FUTURE POSSIBILITIES IN CLINICAL MEDICINE

Lee E. Farr, *Upton New York; Medical Director, Brookhaven National Laboratory and Physician-in-Chief, Brookhaven National Laboratory Hospital, Upton, New York*

1:00 LUNCHEON, Cafeteria

VISIT TO TECHNICAL EXHIBITS

AUDITORIUM

Program arranged by Hartford Hospital

2:00 Historical and Clinical Meeting Commemorative of the Founding of the Hartford Hospital in 1854

HISTORY OF THE HARTFORD HOSPITAL

Stanley B. Weld, *Hartford; Visiting Obstetrician and Gynecologist, Hartford Hospital*

INCIDENTS AND ANECDOTES OF THE HARTFORD HOSPITAL

Robert A. Goodell, *Hartford; Honorary Staff, Hartford Hospital*

2:45 CLINICOPATHOLOGICAL CONFERENCE

Departments of Pathology and Medicine

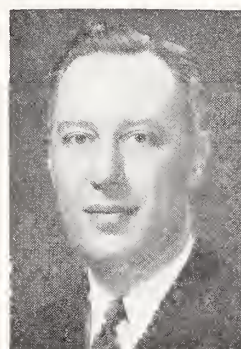
*Henry A. Schroeder*, St. Louis, Missouri; Associate Professor of Medicine, Washington University School of Medicine; Assistant Physician, Barnes Hospital, St. Louis; Director of Hypertension Division, Department of Internal Medicine, Washington University School of Medicine.



*Edward J. Welch*, Boston, Mass.; Assistant Chief of Staff, Channing Home for Pulmonary Tuberculosis, Boston, Mass.; Instructor in Medicine, Boston University School of Medicine.



*Lester Adelson*, Cleveland, Ohio; Assistant Professor of Legal Medicine, Western Reserve School of Medicine; Pathologist and Chief Deputy Coroner, Cuyahoga County Coroner's Office, Cleveland, Ohio.



*Lee E. Farr*, Upton, New York; Medical Director and Physician-in-Chief, Brookhaven National Laboratory; Member National Research Council.

## Wednesday, April 28

### ROOM 169

HUGH K. MILLER, *Stamford*, presiding

#### 10:00 HAEMORRHAGE, A FOREMOST PROBLEM IN OBSTETRICS

*Duncan E. Reid*, Boston, Massachusetts; *Obstetrician-in-Chief*, Boston Lying-In Hospital; *William Lambert Richardson* Professor of Obstetrics, Harvard Medical School

#### 10:45 TOWARD SAFER BLOOD TRANSFUSION

*Alan Richardson Jones*, Boston, Massachusetts; *Research Associate*, Department of Pediatrics, Harvard Medical School; *Associate Director*, Blood Grouping Laboratory of Boston; *Research Associate in Hematology*, Children's Medical Center, Boston; *Associate Hematologist*, Boston Lying-In Hospital

Discussion opened by *Daphne Richardson Jones*, Boston, Massachusetts

#### 11:30 INTERMISSION TO VISIT TECHNICAL EXHIBITS

MARVIN LILLIAN, *Bridgeport*, presiding

#### 12:00 THE TREATMENT OF ACUTE RENAL FAILURE

*Roy C. Swan, Jr.*, New York; *Assistant Professor of Physiology*, Cornell University Medical College, New York

#### 1:00 LUNCHEON, Cafeteria

VISIT TO TECHNICAL EXHIBITS



Wednesday, April 28

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

TENTH ANNUAL MEETING

TRINITY COLLEGE, HARTFORD

President: Mrs. Dewey Katz, *Hartford* Secretary: Mrs. Stevens J. Martin, *Hartford*

10:30 REGISTRATION—Trinity Library Conference Room

11:00 Business Meeting

12:30 Social Hour—Cook Lounge

1:15 Lunchcon—Hamlin Dining Hall

WELCOME BY DR. ALBERT C. JACOBS, PRESIDENT, TRINITY COLLEGE

GUEST SPEAKER

JOHN J. BLASKO, COMMISSIONER OF MENTAL HEALTH FOR STATE OF CONNECTICUT

SECTION ON ANESTHESIA

3:30 Room 145

President: Frank H. D'Andrea, *Stamford* Secretary: Leopold M. Trifari, *New Haven*

3:30 MEDICO-LEGAL RESPONSIBILITY OF THE ANESTHESIOLOGIST

Cyril Coleman, *Hartford*; *Attorney-at-Law*

SECTION ON DERMATOLOGY

3:30 Room 303

President: F. Wellington Brecker, *Hartford* Secretary: Jack J. Albom, *New Haven*

3:30 RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF PEMPHIGUS

Walter F. Lever, *Boston*; *Clinical Associate in Dermatology, Harvard Medical School*

SECTION ON PROCTOLOGY

3:30 Room 336

President: Frederick S. Ellison, *Hartford* Secretary: Angelo L. Gentile, *New Haven*

EFFECT OF MINERAL OIL ON THE ABSORPTION OF FAT SOLUBLE VITAMINS

William A. Krehl, PH.D., *New Haven*; *Associate Professor of Nutrition, Yale University School of Medicine*

Discussion of medical and surgical aspects will follow

SECTION ON RADIOLOGY

3:30 Room 333

President: Fred Zaff, *New Haven*

Secretary: William A. Goodrich, *Hartford*

ANEURYSM OF THE THORACIC AORTA

George Levene, *Boston*; *Radiologist, Massachusetts Memorial Hospital; Associate Professor of Radiology, Boston University*

Wednesday, April 28

SECTION ON GASTROENTEROLOGY

3:30 Room 236

President: Milton M. Lieberthal, *Bridgeport* Secretary: Sydney Selesnick, *West Haven*

PANEL DISCUSSION ON DYSPHAGIA AND HEARTBURN

Moderator: Sydney Selesnick, *West Haven*; *Chief of Gastroenterology Section, Veterans Administration Hospital, West Haven*; *Assistant Clinical Professor of Medicine, Yale University School of Medicine*

PHYSIOLOGICAL CONSIDERATIONS

Franz J. Ingelfinger, *Boston*; *Chief of Gastroenterology, Massachusetts Memorial Hospital*; *Consultant in Gastroenterology, Boston Veterans Administration Hospital*

DIAGNOSTIC AND CLINICAL CONSIDERATIONS

Moses Paulson, *Baltimore, Maryland*; *Assistant Professor of Medicine, The Johns Hopkins School of Medicine*; *Physician to the Johns Hopkins Hospital*; and *Consultant in Digestive Diseases to its Diagnostic Clinic and Private Out-Patient Service, Baltimore*

SURGICAL ASPECTS

Albert S. Lyons, *New York*; *Adjunct Attending Surgeon, Chief Gastric Clinic and Intestinal Rehabilitation Clinic, Mount Sinai Hospital, New York*

JOINT MEETING

3:30 Room 169

CONNECTICUT SOCIETY OF PATHOLOGISTS

President: John E. Thayer, *Hartford* Secretary: Bernard F. Mann, *New Haven*

CONNECTICUT ASSOCIATION OF MEDICAL EXAMINERS

President: Brae Rafferty, *Willimantic* Secretary: Samuel B. Rentsch, *Derby*

POST MORTEM INVESTIGATION OF SUDDEN DEATH

Lester Adelson, *Cleveland, Ohio*; *Assistant Professor of Legal Medicine, Department of Pathology, Western Reserve School of Medicine, Cleveland, Ohio*; *Pathologist and Chief Deputy Coroner, Cuyahoga County Coroner's Office, Cleveland, Ohio*

CONNECTICUT ALLERGY SOCIETY

2:30 Room 337

President: Irving H. Uvitsky, *Bridgeport* Secretary: Eugene H. Walzer, *Bridgeport*

2:30 Business Meeting

3:30 COMMON ERRORS IN THE MANAGEMENT OF ALLERGIC DERMATOSES

Rudolf L. Baer, *New York*; *Associate Director, Skin and Cancer Unit, Associate Professor, Clinical Dermatology and Syphilis, New York University Post-Graduate Medical School*



Wednesday, April 28

CONNECTICUT ASSOCIATION OF MEDICAL RECORD LIBRARIANS

Room 222

President: Mrs. Grace Margerum, *Rocky Hill* Secretary: Miss Janet Davis, *Middletown*

10:00 Greetings

Mrs. Grace Margerum, R.R.L., *President, Connecticut Association, Medical Record Librarians*

10:05 PROBLEMS IN CODING DISEASES AND OPERATIONS

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS

Miss Florence M. Fitzgerald, R.R.L., *Chief Medical Records Librarian, New Britain General Hospital*

11:00 PROBLEMS IN HOSPITAL STATISTICS

Mrs. A. Louise Kelsey, R.R.L., *Chief Medical Records Librarian, Grace-New Haven Hospital*

12:00 Luncheon

2:30 Greetings

Miss E. Louise Seymour, *President American Association Medical Record Librarians*

3:30 JOINT MEETING WITH CONNECTICUT REGIONAL GROUP OF THE MEDICAL LIBRARY ASSOCIATION

DIAGNOSIS AND TREATMENT OF OPERABLE HEART DISEASES

Howard Levine, *New Britain; Senior Attending Physician and Cardiologist, New Britain General Hospital*

R. Leonard Kemler, *Hartford; Attending Thoracic Surgeon, Cedarcrest and Undercliff Sanatoria; U. S. Veterans Hospital, Newington*

The Medical Record Librarians from Massachusetts, Rhode Island, New York, and New Jersey will join the Connecticut Association for this meeting

CONNECTICUT REGIONAL GROUP—MEDICAL LIBRARY ASSOCIATION

Room 226

President: Mrs. Sadie M. Karpman, *New Britain*

Secretary: Miss Clara Libby, *Hartford*

3:00 Business Meeting

3:30 Joint Meeting with Connecticut Association of Medical Record Librarians in Room 222

CONNECTICUT BRANCH OF AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS

3:30 Room 134

Chairman: Mrs. Victoria Shannon, *New Haven*

Secretary: Miss Anne Robertson, *New Haven*

HOW DO WE HELP PARENTS OF A CHILD WITH A CONGENITAL DEFECT?

Moderator: John C. Leonard, *Director of Medical Education and Clinical Director, Hartford Hospital*

Panel:

Morris A. Wessel, *Assistant Clinical Professor of Pediatrics, Yale Medical School*

Charles B. Cheney, *Assistant Clinical Professor of Obstetrics and Gynecology, Yale Medical School*

Mrs. Marguerite Gelinas, *Social Worker on Pediatrics, Grace-New Haven Community Hospital*

Miss Katherine Davis, *Administrative Supervisor of the Children's Service, Grace-New Haven Community Hospital*

Mrs. Alberta DeRongé, *Medical Social Worker, Division of Crippled Children, Connecticut State Department of Health*

Wednesday, April 28

CONNECTICUT OCCUPATIONAL THERAPY ASSOCIATION

3:30 Room 135

President: Mrs. Alice Rogers, *Middletown* Secretary: Miss Mary Fiorentino, *Newington*

OCCUPATIONAL THERAPY—A COMMUNITY SERVICE

Miss Margaret Macgregor, O.T.R., *Administration Assistant and Coordinator, Mobility, Inc., White Plains, New York*

CONNECTICUT RHEUMATISM ASSOCIATION

3:30 Room 108

President: David S. Greenspun, *Bridgeport* Secretary: Harold S. Barrett, *Hartford*

ARTHRITIS DUE TO TUBERCULOSIS

Edward F. Hartung, *Assistant Clinical Professor of Medicine, Postgraduate Medical School, New York University*

Annual Dinner of the Society

HARTFORD CLUB

46 Prospect Street, Hartford, Connecticut

7:00

PROGRAM

GEORGE H. GILDERSLEEVE, *presiding*

INTRODUCTION OF NEWLY ELECTED OFFICERS

PRESENTATION OF GUESTS AND DELEGATES FROM STATE MEDICAL SOCIETIES

FIFTY YEAR MEMBERSHIP AWARDS

Harold Simeon Backus, *Hartford*

Robert Joseph Lynch, *Bridgeport*

William Harold Van Strander, *Hartford*

Orin Russell Witter, *West Hartford*

JOHN C. LEONARD, *presiding*

THE LAST ONE HUNDRED YEARS

Wilmar M. Allen, *Retired Director of Hartford Hospital*

LOOKING AHEAD ONE HUNDRED YEARS

T. Stewart Hamilton, *Director of Hartford Hospital*

THE IMPORTANCE OF COOPERATION BETWEEN THE LAY BOARD OF DIRECTORS AND THE MEDICAL STAFF OF A COMMUNITY HOSPITAL

Mr. Francis W. Hatch, *Board of Directors, Massachusetts General Hospital, Advertising Executive, Boston, Massachusetts*

ENTERTAINMENT

Linen Dusters Quartet

Reservation cards for the Annual Dinner will be included with the program of the meeting which will be distributed to all members; wives of members are invited to attend



Thursday, April 29

AUDITORIUM

9:00 REGISTRATION—Exhibit Hall

9:15 MOTION PICTURE FILM

JOHN F. NOLAN, *Bridgeport, presiding*

10:00 MANAGEMENT OF RECURRENT INTESTINAL OBSTRUCTION

Victor P. Satinsky, *Philadelphia; Director of Surgical Research, Albert Einstein Medical Center; Assistant Surgeon and Instructor in Surgery, Hahnemann Medical College*

10:35 RECENT ADVANCES IN THE SURGICAL TREATMENT OF CERTAIN VASCULAR LESIONS

Gerald H. Pratt, *New York; Associate Clinical Professor of Surgery, New York University, College of Medicine; Attending Surgeon and Chief of Vascular Service, St. Vincent's Hospital, New York*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

STEVENS J. MARTIN, *Hartford, presiding*

11:40 RESUSCITATION OF THE ACUTELY ARRESTED HEART

Hugh E. Stephenson, Jr., *Columbia, Missouri; Assistant Professor of Surgery, University of Missouri School of Medicine, Columbia, Missouri*

12:20 SURGICAL TREATMENT OF CORONARY INSUFFICIENCY

Arthur Vineburg, *Montreal, Quebec; Surgical Staff, Royal Victoria Hospital, Montreal; Lecturer in Surgery, McGill University; Director of Cardio-Thoracic Surgery, Jewish General Hospital; Consultant Cardiac Surgery, Queen Mary Veterans Hospital*

1:00 LUNCHEON, Cafeteria

VISIT TO TECHNICAL EXHIBITS

2:00 SYMPOSIUM ON BILIARY TRACT DISEASE

Arranged by The Connecticut Society of American Board Surgeons

President: Courtney C. Bishop, *New Haven* Secretary: Alfred Hurwitz, *West Haven*

THE DIFFERENTIAL DIAGNOSIS OF JAUNDICE

Henry J. Tumen, *Bockus Group, Pennsylvania, Associate Professor of Gastroenterology, Graduate School, University of Pennsylvania*

INDICATIONS FOR BILIARY TRACT SURGERY

Samuel W. Moore, *Attending Surgeon, New York Hospital; Associate Professor of Clinical Surgery, Cornell Medical School*

SURGICAL TREATMENT OF COMPLICATIONS FOLLOWING BILIARY TRACT SURGERY

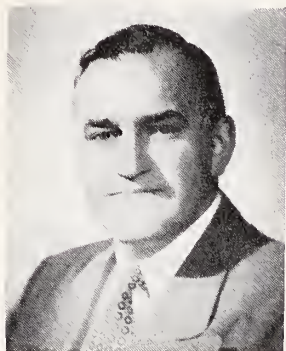
Speaker to be announced

PATHOLOGICAL CONSIDERATIONS IN BILIARY TRACT DISEASE

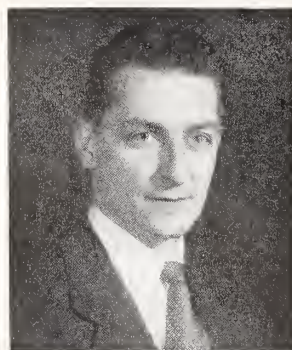
Raymond Yesner, *Chief Pathologist, Veterans Administration Hospital, West Haven, Connecticut; Associate Clinical Professor of Pathology, Yale University School of Medicine*

3:30 Intermission

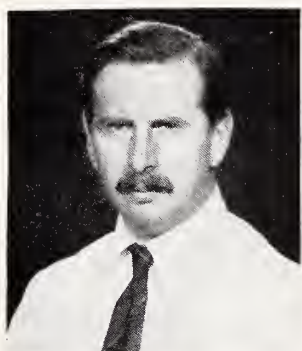
3:45 ROUND TABLE DISCUSSION



*Duncan E. Reid*, Boston, Mass.; William L. Richardson Professor of Obstetrics, Harvard Medical School; Obstetrician-in-Chief, Boston Lying-in Hospital.



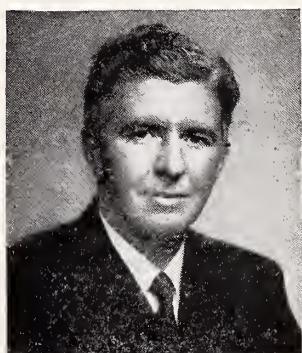
*Roy C. Swan, Jr.*, New York City; Assistant Professor of Physiology, Cornell University Medical College, New York.



*Alan Richardson Jones*, Boston, Mass.; Research Associate, Department of Pediatrics, Harvard Medical School; Associate Director, Blood Grouping Laboratory of Boston; Research Associate in Hematology, Children's Medical Center, Boston; Associate Hematologist, Boston Lying-in Hospital.



*Victor P. Satinsky*, Philadelphia, Pa.; Associate Surgeon and Director of Surgical Research, Albert Einstein Medical Center; Instructor in Surgery, Hahneman Medical College.



*Gerald H. Pratt*, New York City; Associate Clinical Professor of Surgery, New York University, College of Medicine; Attending Surgeon and Chief of Vascular Service, St. Vincent's Hospital, N. Y.



*Hugh E. Stephenson, Jr.*, Columbia, Missouri; Assistant Professor of Surgery, University of Missouri, School of Medicine.



Thursday, April 29

ROOM 169

- 9:15 MOTION PICTURE FILM—ORAL CANCER: THE PROBLEM OF EARLY DIAGNOSIS  
(Courtesy American Cancer Society—Connecticut Division)

N. WILLIAM WAWRO, *Hartford, presiding*

- 10:00 RECONSTRUCTIVE SURGERY OF THE FACE

Richard H. Walden, M.D., D.D.S., *New York; Attending Plastic and Maxillo-Facial Surgeon, Nassau Hospital, Mineola, New York; North Country Community Hospital, Glen Cove, New York; Mercy Hospital, Rockville Centre, New York; Assistant Visiting Plastic and Maxillo-Facial Surgeon, Kings County Hospital, Brooklyn, New York*

- 10:45 THE CONTRIBUTION OF THE ORAL SURGEON

Daniel J. Holland, D.M.D., *Boston Massachusetts; Professor of Oral Surgery and Chairman of the Department, Tufts Medical and Dental School; Oral Surgeon, New England Medical Center; Consulting Oral Surgeon, Massachusetts General Hospital*

- 11:30 INTERMISSION TO VISIT TECHNICAL EXHIBITS

NORTON CANFIELD, *New Haven, presiding*

- 12:00 MECHANISMS OF VOICE COMMUNICATION

Paul Moore, PH.D., *Evanston, Illinois; Associate Professor of Speech Correction, Director of the Voice Research Laboratory, and Director of the Voice Clinic, a unit of the Ear, Nose, and Throat Department of the Northwestern University Medical School*

- 1:00 LUNCHEON, Cafeteria

VISIT TO TECHNICAL EXHIBITS

### SYMPOSIUM ON DIABETES

BURDETTE J. BUCK, *Hartford, presiding*  
President, Connecticut Diabetes Association

- 2:00 ENDOCRINE CONTROL OF DIABETES

C. N. H. Long, *Sterling Professor of Physiology, Yale School of Medicine, New Haven*

- 3:00 PANEL DISCUSSION

C. N. H. Long, *New Haven*

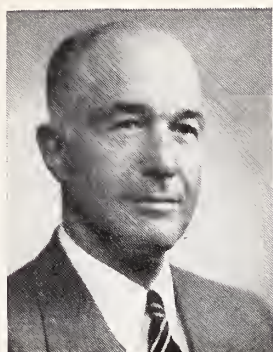
Burdette J. Buck, *Hartford*

Samuel Donner, *Hartford*

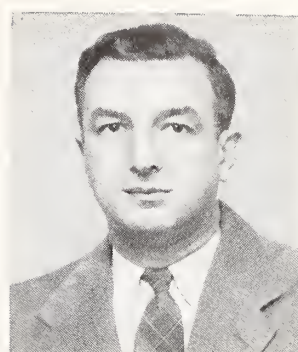
Barnett Greenhouse, *New Haven*

Mrs. Alice Scanlon, *Diabetic Supervisor, Hartford Hospital*

There will be a discussion of the diagnosis of diabetes, the Diabetic Clinic, the Hospital Diabetic Service and the teaching of the diabetic in the hospital. This will be followed by a question period.



*Arthur Vineberg*, Montreal, Quebec; Member of Surgical Staff, Royal Victoria Hospital, Montreal, Quebec; Lecturer in Surgery, McGill University; Director of Cardio-Thoracic Surgery, Jewish General Hospital; Director of Surgery, Grace Dart Hospital.



*Richard H. Walden*, Hempstead, N. Y.; Attending Plastic and Maxillo-Facial Surgeon, Nassau Hospital, Mineola, North Country Community Hospital, Glen Cove, and Mercy Hospital, Rockville Centre; Assistant Visiting Plastic and Maxillo-Facial Surgeon, Kings County Hospital, Brooklyn; Assistant Attending Plastic and Maxillo-Facial Surgeon, Meadowbrook Hospital, East Meadow.



*Daniel J. Holland, Jr.*, Boston, Mass.; Professor of Oral Surgery and Chairman of the Department, Tufts Medical and Dental School; Oral Surgeon, New England Medical Center.



*Paul Moore*, Evanston, Ill.; Associate Professor of Speech Correction, Director of the Voice Research Laboratory and Director of the Voice Clinic, Northwestern University Medical School.

## Thursday, April 29

### MEETING OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

#### EYE, EAR, NOSE AND THROAT SECTION

3:30 Room 236

President: James F. Cobey, *New Haven*

Secretary: Max Alpert, *Bridgeport*

#### CORRECTION OF THE DEVIATED NOSE

Irving Goldman, *Chief of Rhinoplastic Division, Mt. Sinai Hospital, New York*

#### ORBITAL TUMORS

Virgil G. Casten, *Ophthalmic Surgeon, Massachusetts Eye and Ear Infirmary*



Thursday, April 29

JOINT MEETING

3:30 Room 222

CONNECTICUT SOCIETY OF AMERICAN BOARD OBSTETRICIANS AND  
GYNECOLOGISTS, INC.

President: Eric H. Blank, *New London*

Secretary: Louis F. Middlebrook, Jr., *Hartford*

SECTION ON OBSTETRICS AND GYNECOLOGY

President: Clair B. Crampton, *Middletown* Secretary: Orvan W. Hess, *New Haven*

POLYCYSTIC OVARIAN DISEASE: ITS DIAGNOSIS AND TREATMENT BY WEDGE RESECTION (Report of thirty-six cases)

Charles Lee Buxton, *Professor and Chairman of Department of Obstetrics and Gynecology, Yale University Medical School, New Haven*

SECTION ON ORTHOPEDICS

President: William S. Perham, *New Haven*

Secretary: George G. Fox, *Meriden*

OSTEOID OSTEOMA

Lee Ramsey Straub, *Associate Attending Orthopedic Surgeon at the Hospital for Special Surgery, New York; Instructor in Surgery, Cornell*

(The time and location of this meeting will be announced later)

SECTION ON PHYSICAL MEDICINE

3:30 Room 303

President: John C. Allen, *Hartford*

Secretary: Samuel A. Schuyler, *Hartford*

THE PATIENT WITH CARDIOVASCULAR DISEASE AND REHABILITATION

Joseph G. Benton, *Coordinator of Education and Research, Institute of Physical Medicine; Assistant Professor, Department of Physical Medicine and Rehabilitation, New York University College of Medicine*

CONNECTICUT SOCIETY FOR PSYCHIATRY AND NEUROLOGY

3:30 Room 145

President: Bernhard A. Rogowski, *New Haven*

Secretary: Sidney Berman, *West Haven*

THE FORCED SOLUTION

John Donnelly, *Clinical Director, Institute of Living, Hartford*

CONNECTICUT CHAPTER AMERICAN PHYSICAL THERAPY ASSOCIATION

2:00 Room 333

President: Mrs. Anne C. Maes, *New Haven*

Secretary: Miss Arlene Lenners, *New Haven*

REHABILITATION IN CARDIOPULMONARY DISEASES

Frieda G. Gray, *Chief of Medicine, Woodruff Restorative Center, New Haven*

3:30 The Physical Therapy Association will join the Section on Physical Medicine in Room 303

## Thursday, April 29

## SECTION ON UROLOGY

3:30 Room 336

Chairman: Charles E. Jacobson, Jr., *Hartford*Secretary: Henry M. Pollock, Jr., *Bristol*

## 3:30 ANATOMY OF THE MALE PERINEUM

Motion Picture Film by R. Theodore Bergman, *Associate Professor of Urology, College of Medical Evangelists, Los Angeles, California*

## 4:00 SIMPLE AND RADIAL PERINEAL PROSTATECTOMY

Motion Picture Films by Elmer Belt, *Urologist-in-Chief, Elmer Belt Urologic Group, Los Angeles, California*

## 4:30 DETECTION AND TREATMENT OF EARLY PROSTATIC CANCER

Perry B. Hudson, *Urologist-in-Chief, Francis Delafield Hospital, New York*

## HEZEKIAH BEARDSLEY PEDIATRIC CLUB

3:30 Room 134

President: Maxwell Bogin, *Bridgeport*Secretary: Stuart L. Joslin, *Fairfield*

## THE TREATMENT OF INFECTION IN THE NEWBORN

Stewart H. Clifford, *Chief of Premature Service and Physician, The Children's Hospital, Boston; Associate in Pediatrics, Harvard Medical School*

## CONNECTICUT REHABILITATION ASSOCIATION

12:30

EDRICH RESTAURANT, 1943 BROAD STREET, HARTFORD, CONNECTICUT

President: Mr. Frederick S. Kelley, *Hartford*Secretary: Mr. Cyrus G. Flanders, *Hartford*

## THE STATE PROGRAM FOR AID TO THE CHRONICALLY DISABLED

Howard E. Houston, *Commissioner of Welfare, State of Connecticut*

## VETERANS ADMINISTRATION

Room 103

F. J. Ryan, Chief Medical Officer

William H. Feery, Medical Administrative Officer

Physicians are invited to stop in and discuss the fee basis treatment program for veterans

## ART EXHIBIT

## CONNECTICUT PHYSICIANS' ART ASSOCIATION

Rooms 141-142

Exhibit Committee

Mrs. Louis Spekter, 23 Vineland Terrace, Hartford

Frederick W. Roberts, 158 Whitney Avenue, New Haven

The 1954 exhibit of the Connecticut Physicians' Art Association will be held during the Annual Meeting in Rooms 141 and 142 of the Bulkeley High School. Members of the Woman's Auxiliary to the Society will again participate in the exhibit and as a special feature, children of Society members are invited to submit entries.



## Technical Exhibits — 1954 Annual Meeting

The Coca-Cola Company, Atlanta, Ga.  
 C. B. Fleet Company, Inc., Lynchburg, Va.  
 Burroughs Wellcome & Co., (U. S. A.), Inc. Tuckahoe, N. Y.  
 The Baker Laboratories, Inc., Cleveland, Ohio  
 S. E. Massengill Company, Bristol, Tenn.  
 Abbott Laboratories, North Chicago, Ill.  
 P. Lorillard Company, New York, N. Y.  
 Mead Johnson & Company, Evansville, Ind.  
 Schering Corporation, Bloomfield, N. J.  
 E. R. Squibb & Sons, New York, N. Y.  
 Ayerst Laboratories, New York, N. Y.  
 Warner-Chilcott Laboratories, New York, N. Y.  
 The Stuart Company, Chicago, Ill.  
 The American Surgical Supply & Equipment Company,  
 Bridgeport, Conn.  
 Brewer & Company, Inc., Worcester, Mass.  
 Lederle Laboratories Division, American Cyanamid Com-  
 pany, Pearl River, N. Y.  
 W. B. Saunders Company, Philadelphia, Pa.  
 E. L. Washburn & Company, Inc., New Haven, Conn.  
 Ciba Pharmaceutical Products, Inc., Summit, N. J.  
 Bilhuber-Knoll Corporation, Orange, N. J.  
 Smith, Kline & French Laboratories, Philadelphia, Pa.  
 H. J. Heinz Company, Pittsburgh, Pa.  
 Ames Company, Inc., Elkhart, Ind.  
 G. D. Searle & Company, Chicago, Ill.  
 Professional Equipment Company, New Haven, Conn.  
 Irwin Neisler & Company, Decatur, Ill.  
 The Borden Company, New York, N. Y.

A. H. Robins Company, Inc., Richmond, Va.  
 The D. G. Stoughton Company, Hartford, Conn.  
 Ives-Cameron Company, Inc., New York, N. Y.  
 White Laboratories, Inc., Kenilworth, N. J.  
 Winthrop-Stearns, Inc., New York, N. Y.  
 R. J. Reynolds Tobacco Company, Winston-Salem, N. C.  
 Wyeth Laboratories (technical exhibit), Philadelphia, Pa.  
 Pfizer Laboratories, Brooklyn, N. Y.  
 Connecticut Hospital Equipment & Supply Company, Hart-  
 ford, Conn.  
 Wm. P. Poythress & Company, Inc., Richmond, Va.  
 Doho Chemical Corporation, New York, N. Y.  
 U. S. Vitamin Corporation, New York, N. Y.  
 Parke, Davis & Company, Detroit, Mich.  
 Surgeons & Physicians Supply Company, Boston, Mass.  
 Vanpelit & Brown, Inc., Richmond, Va.  
 E. Fougera & Company, Inc., New York, N. Y.  
 Eli Lilly & Company, Indianapolis, Ind.  
 Cott Beverage Corporation, New Haven, Conn.  
 Sealy Mattress Company, Waterbury, Conn.

### EXHIBITS IN CORRIDOR AND LOBBY

E. F. Mahady Company, Boston, Mass.  
 M & R Laboratories, Columbus, Ohio  
 Wyeth Laboratories (scientific exhibit), Philadelphia, Pa.  
 Fellows Medical Mfg. Company, Inc., New York, N. Y.  
 Pepperidge Farm, Inc., Norwalk, Conn.  
 Saratoga Springs Authority, Saratoga Springs, N. Y.  
 Bedford Surgical Company, Inc., Brooklyn, N. Y.  
 Wilfred Pharmaceutical Company, Hamden, Conn.



BULKELEY HIGH SCHOOL

## HARTFORD HOSPITAL: A CENTURY OF SERVICE

LYDIA B. HEWES, *Hartford*

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The Author. *Director of Public Relations,  
Hartford Hospital*

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HARTFORD in 1854 was a prosperous city with a population of some 18,000 souls. It had a handsome State House of Bulfinch design, a museum and a number of schools and churches. Trinity College stood on the site later to be occupied by the new capitol building. The first Deaf and Dumb Asylum in the United States had already given its name to Asylum Hill, and the Retreat for the Insane had been established since the 1820's. There were insurance companies and manufacturing concerns to add to the atmosphere of comfortable prosperity. But there was no public hospital.

The large majority of citizens apparently saw no need for an institution of this sort. The place for people when sick was at home! The destitute could be cared for at the City Almshouse. However, a few of the far sighted felt concern. The progress of the hospital founded in 1821 in the rival capitol city, New Haven, was noted. In 1851 the Hartford Medical Society set up a committee to investigate the possibilities of establishing a small hospital in Hartford at a moderate cost. Members of Christ Church had taken a step forward in 1852 by founding a Society to provide a Home for the Sick, which was located in a house at the junction of what is now Maple and Retreat Avenues. It could care for only a limited number of persons.

Any apathy as to a hospital was destroyed over night by a terrible disaster. On March 2, 1854 an explosion of a boiler in the Fales and Gray Car factory killed nineteen and injured twenty-three! There was no place to care for the victims! Public indignation ran high and there were newspaper editorials demanding action! All this culminated on May 2 with a crowded meeting which voted for a corporation to be formed and to be called Hartford Hospital. A charter and constitution were subsequently drawn up and approved, and at the May

session of the legislature the act of incorporation was passed. The bill was then signed by the Governor, Henry Dutton. This meant that the hospital corporation was now legal.

Francis Parsons was named the first president of Hartford Hospital at a meeting held in February, 1855. A Board of Directors was set up and plans made to raise money for a building fund of \$20,000 to be augmented by \$10,000 from the State. About nine acres was purchased near South Green. Meanwhile it was voted to take over the assets of the Home for the Sick, including its debts, and to rent the house as a temporary place to care for patients until the new hospital opened. The assets of the Home were listed, including such items as feather beds and bolsters, husk mattresses, straw beds, duck blankets, pantaloons, night caps, Bibles and Prayer Books.

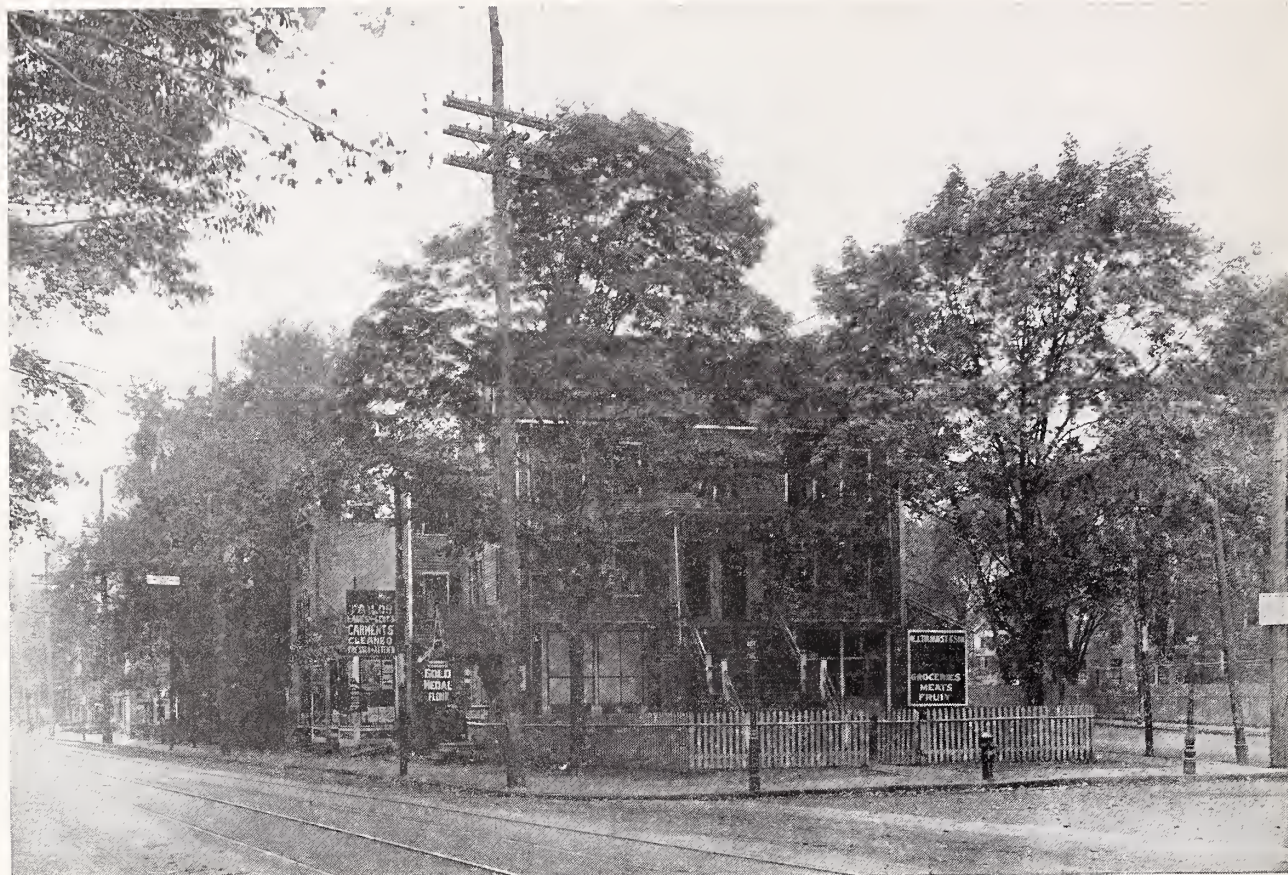
The plans for the new hospital were modelled after the New York Hospital, and it may have been a coincidence that nearly eighty years later the firm of architects, Coolidge, Shepley, Bulfinch and Abbott, was engaged to design a new Hartford Hospital. It was this firm which had recently designed New York Hospital's modern building on the Hudson River. The latest heating and ventilating systems were installed in this first Hartford Hospital and the large wards with high ceilings were considered to provide fine accommodations. Construction was of brown sandstone, quarried in Portland.

The doors finally opened to admit patients on August 1, 1860. This was a great day for the city and the start of a new era of health progress in the city of Hartford.

### THE COMMUNITY PARTICIPATES

From its birth in 1854 Hartford Hospital was a community affair, "of the people, by the people, for the people." Through the years it is the people who have furnished business and industrial leaders to serve as officers and directors of the corporation. These men have always given freely of their time to





"HOME FOR THE SICK"

First building occupied by Hartford Hospital, corner Maple and Retreat Avenues — 1855

make certain that the hospital is safely and soundly operated.

It is also the people who have been benefactors in their wills. The first of these was David Watkinson who in 1860 left \$41,000 to the hospital. It is the people who have given money for free beds and other purposes; it is the people who have made contributions for new buildings, additions and improvements.

Following the first successful money-raising efforts for the original new building there was little respite from this type of activity. The hospital began to grow like Topsy in all directions when, only a few years after the opening, the forty beds were over taxed. Money had to be raised for a south wing and two cross wings increasing the capacity to 100 beds. From this point on there was a recurrent need for more money to provide for more growth. By the turn of the century there had been added at least fifteen building projects as well as an Old

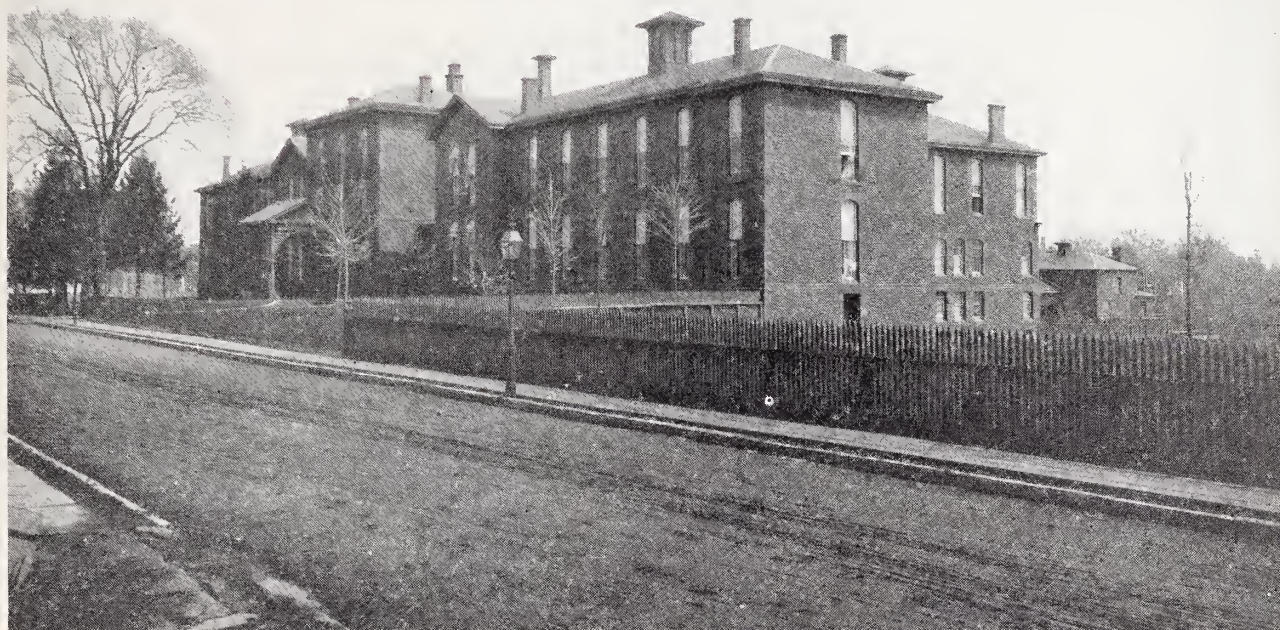
People's Home opened in 1880 and the Nurses' Residence opened in 1900.

When the years of World War II arrived, the entire nine acres were crowded with a motley array of structures, including the Cheney Memorial Library, Hall-Wilson Laboratory, and the Elizabeth C. P. Bell Power House. In 1932 the Avery Convalescent Hospital had been opened on property only a ten minute car drive from the main hospital.

One of the founding fathers in his dedicatory address, back in 1859, had expressed his opinion that the new hospital would be standing for hundreds of years to come. Yet a mere eighty years saw the old plant outmoded. There was no room for further expansion in the present setup. It was then that members of the Board of Directors made the radical decision to build a completely new structure on land across the way on the west side of Hudson Street.

In 1942-1943 a building fund drive, led by James B. Slimmon, successfully raised over \$5,000,000 for





HARTFORD HOSPITAL — 75 YEARS AGO

this purpose. Much of the money was given as memorials for rooms and wings in the proposed building. Due to wartime shortages and raising prices it was necessary to raise an additional \$2,000,000. This was accomplished in 1948 under the chairmanship of Ostrom Enders.

Fortunately for the wartime boom in babies, part of the new building project got a headstart with the completion of South Building as the maternity section in 1942. Actually this section had been included as part of an 18 story skyscraper but the proximity of an airfield with its take-offs and landings made it necessary to lop off five stories. These became the South Building and contained rooms for mothers and 150 baby bassinets.

The war put a stop to further activity but nine days after V-J day ground was broken for the present High Building. This was dedicated on March 14, 1948 and, following a three day moving operation, was opened for admission of patients on March 29. During this procedure 361 patients were transferred from old quarters to new.

Thus Hartford Hospital became the first new complete hospital to be built after the end of the war. From the start it attracted wide interest from all parts of the world because of its modern features, such as oxygen-making plant, conveyor belts and other labor-saving features. Nor was this the end of physical growth. By 1949 a Medical Building had been constructed by the Connecticut Mutual Life Insurance Company on hospital property and connected with High Building. In 1951 a fine new laundry opened, costing \$561,000. One-third of this amount was supplied by the Hill-Burton Act.

Not only have individuals supported the hospital through gifts and donations. In recent years industry and business have given financial assistance. In October 1953 the United Aircraft Company donated \$100,000 for purchase of new high-voltage radiological equipment for treatment of deep seated cancer. This will probably be installed during the next twelve months. In December five local life insurance companies announced assistance amounting to \$25,000 over a five year period for the new and



expanded research program. This research has been earmarked to start with a cardiorespiratory program.

The Centennial year is a happy vantage point at which the hospital can pause to count the blessings of community interest and support.

#### THE DOCTORS' PART

Since the beginning the doctors have played an important part in the story of Hartford Hospital. They were active in its founding, and in the initial stages; they have been active ever since in caring for the patients here.

The staff began to function directly following the explosion disaster in March, 1854 in the "Home for the Sick," anticipating a new hospital. In 1855 the directors of the Hospital asked the Hartford Medical Society to appoint six members to form the first staff. The men named, who had already served the "Home for the Sick" were Drs. A. W. Barrows, Samuel B. Beresford, George F. Hawley, E. K. Hunt, Gurdon W. Russell and Myron W. Wilson. Since Dr. Wilson died shortly after appointment, Dr. David Crary was asked to take his place.

Dr. Hawley helped to raise funds and procure plans for the first building; he spoke at the laying of the cornerstone in 1857 and at the dedication in 1859. At this latter ceremony he stressed the fine heating and ventilating of the plant, which praise, in view of latter day progress, induces one to comment "Vanity, vanity, all is vanity!" He was active on the first Executive Committee and continued on it almost until his death in the hospital in 1883. In recognition of twenty-eight years of valuable service, a tablet was placed by the Board of Directors in the Staff Room, later the Business Manager's Office. Among other memorials was one to Dr. Samuel B. Beresford of the first staff, in the form of a stained glass window given by his widow and children which has a place in the new building and will some day adorn a proposed chapel.

Dr. Gurdon W. Russell is significant as the man who presented the case for the hospital at that first public meeting on May 2, 1854. He became the fifth president of the Hospital in 1888, a position held by only one other doctor, Harmon G. Howe, who was his successor. In 1903 Dr. Russell became president emeritus, holding the title until his death in 1909.

These first staff doctors set the pattern for local medical men in after years. Large numbers of these have given care on the rotating service without

charge to those unable to pay. This has been an act of charity beyond computation in value in dollars and cents. Members of the staff still give this care to service patients each year. In fact, it was not until 1906 that doctors were allowed to charge their private patients who had been admitted to the Hospital.

The first staff of six men has increased like everything else during the Hospital's history until last year 687 men were listed on the medical and surgical staff, the consulting and courtesy staffs. First presi-



GEORGE B. HAWLEY

dent (or chairman) of the Medical and Surgical Staff is recorded as Dr. Gurdon W. Russell, who held office from 1885 to 1909. He was followed by Drs. Harmon G. Howe, G. Pierrepont Davis, Phineas H. Ingalls, Walter R. Steiner, Alfred M. Rowley, Edward R. Lampson, Orin R. Witter, John C. Rowley, H. Gildersleeve Jarvis, Howard W. Brayton, Donald B. Wells, Otto G. Wiedman, Douglas J. Roberts, Thacher W. Worthen, Stanley B. Weld and now Hartwell G. Thompson.

Clinical medical education entered the picture when the first young doctor, Robert B. Goodyear, completed his internship here. This educational program has expanded through the years. Over 550 interns have graduated under the rotating system, among them many men who have attained high honors in their profession, such as the recently retired surgeon general of the United States Army,

Raymond W. Bliss, a member of the 1911 intern group.

Clinical education was given an impetus when Dr. Wilmar M. Allen and Dr. Ralph E. Kendall came here in 1925 as the first fulltime pathologists. Following this change it was only natural that Hartford Hospital should establish a regular schedule of clinics and clinical pathological conferences.

An accredited residency program was initiated following the arrival in 1936 of Dr. Ralph M.



SAMUEL B. BERESFORD

Tovell as head of the Anesthesiology Department. In 1937 the first residents came to study anesthesia. Accredited residencies have since been established in many other departments, and the educational program has received tremendous support since 1944 from Hartford Hospital Association, this support being manifested in actual dollars and cents. At present there are 83 residents and interns on the House Staff, including those in anesthesia.

Other departments have been set up during the years. The first installation of x-ray equipment was made as early as 1904. Physical medicine became an outstanding service after the end of World War II and now has a fulltime physician as director. Departments and clinics now deal with blood diseases, gastroenterology, neurosurgery and neurology, while such as mental hygiene and geriatrics have become subjects for real study by the staff since they relate closely to the general health and well being of the entire community.

There was a so-called Out Department in the hospital in the 1870's but the Outpatient Department with diagnostic services, as it is today, was set up in 1942 by Dr. John C. Leonard. A comprehensive postgraduate medical education program has also made tremendous progress since 1947 under the leadership of Dr. Leonard. This is aimed at the continual education of practising physicians as well as House Staff since such education is deemed invaluable in a world in which spectacular developments change the health picture overnight. It is for this latter reason that the expanded research program has now been adopted at Hartford Hospital and it is expected that this will perform valuable service in the future and be of benefit to the entire community. With this in mind, the Hospital adopted as its Centennial slogan "Saluting a century of service Hartford Hospital looks ahead."

#### HOSPITAL OPERATION

The operation of Hartford Hospital has become increasingly complicated as the years have rolled by. Now it is a major business, involving thousands of individuals and accompanied by the need for wise financing. While the Board of Directors has always been the guiding force in administration, the actual management has been the responsibility of one man. The first of these, W. P. Corrin, was named steward in 1863. After three other incumbents, Dr. James M. Kenniston took office in 1904 and became the first doctor to hold the position. Since then it has been the policy of the hospital to have a physician as its head to coordinate the activities that are necessary for good medical and hospital care. These have been, following Dr. Kenniston, Winford H. Smith, Appleton W. Smith, and Lewis A. Sexton. In 1936, on the death of Dr. Sexton, Dr. Wilmar M. Allen was named director and held the office through 1953. Only recently he relinquished his duties because of his health, and in February Dr. T. Stewart Hamilton, formerly director of Newton-Wellesley (Massachusetts) Hospital, took office. It is he who will guide the administration through its one hundredth year.

#### THE SCHOOL OF NURSING

In a history of the Hospital partially prepared by the late Dr. Walter Steiner it was noted that, when the first building opened in 1860, there was a large room on the second floor that was probably used as a dormitory for nurses and domestics. Actually there was little, if any, mention of nurses or nursing



in annual reports until the issue published in 1877. In this it was stated that it was the intention "to introduce into the organization a training school for nurses. It is designed to select, and educate, an efficient class of women that the Hospital may have a high order of nursing." This was the beginning of the Training School for Nurses, and it was distinguished as the fourth in this country to be modelled according to the Nightingale plan, calling for a lady superintendent as its head. The first to be thus appointed was Mrs. F. A. Tuttle who held office for thirteen years.

From a two year course it was increased in 1900 to three years. In the first graduating class in 1879 there were five students who received diplomas. Since then the School has graduated 2,781 nurses and there are nearly 250 students enrolled in the School at the present time.

In its beginnings the nursing instruction was apparently elementary in nature but was soon augmented with lectures by doctors. One instruction in 1878, which remained in force for many years, was listed in these words: "No part of the Hospital is clean if it can be made cleaner." To date there have been twelve heads of the school.

After the Nurse's Residence was opened in 1900 many additions were built, including Heublein Hall and the Barney Education Building with its swimming pool and gymnasium. Staff nurses were first mentioned in a 1930 report, four being employed in

that year. During World War II, when there were acute nursing personnel shortages, the nursing department turned to volunteers for assistance. It was in this way that the Volunteer "Blue Bird" Corps and Volunteer Medical Aides were created, while the Volunteer Nurse's Aides were trained here in cooperation with the Red Cross. The use of non nursing personnel proved so successful during the war that it has been continued ever since, while the staff of paid employees has been increased by other categories of personnel to assist the professional nurses in bedside and floor care of patients.

In 1948 the nursing service started a cooperative program with the State Board of Education. This called for nine months of clinical experience in the hospital for student trained attendants (now known as student practical nurses). Other workers on the floors are floor receptionists, who do much of the clerical work, and ward helpers who do the house-keeping related to patient care. There are paid as well as volunteer nurse's aides, medical technicians and male aides. All of these come under the supervision of a graduate nurse to form a nursing team. In 1949 Hartford Hospital was one of first and most enthusiastic supporters of the team method, and is proud of its pioneer work in this field.

The program of the School of Nursing is now fully accredited by the Accrediting Service of the National League for Nursing. In addition to the three year program, coordinated programs have been



ABOUT 1880





THE OPERATING ROOM—ABOUT 1900

established with Mount Holyoke College and Hartford College. Nurses taking courses in this way earn a college degree and a nursing diploma at the end of five years.

There are still many problems in regard to nursing as the hospital moves along in its one hundredth year. An increase in the number of patients using hospitals has brought about a great shortage of nurses and nursing personnel. Looking ahead, one can only hope that some productive answers will be forthcoming early in the next century of Hartford Hospital and its School of Nursing.

#### THE DISTAFF SIDE

In news accounts of the laying of the cornerstone in 1856 it was reported by the local press that a "large number of ladies were present." It has been traditional since this time for the women to have an interest in and sympathy for the patients in the

Hospital. In the early days they formed a flower committee to make certain that the wards were kept cheerful with fresh blooms. At Christmas time and on other holidays they brought in jellies, loaf cake, fruit and other good things. They donated magazines and old cotton and linen cloth for bandages. In many instances they were donors of substantial gifts that made new building projects possible. High Building has many memorial plaques that were the result of contributions by women.

In 1921 a major step forward was taken with the formation of The Women's Auxiliary. Its purpose was stated "to foster throughout the community an increased interest in the welfare of the Hartford Hospital; to make hospital supplies and whenever possible to render other auxiliary services as the Hospital desires." Mrs. Louis R. Cheney, wife of the president of the hospital at that time, became the first president of the Auxiliary.



During the first score of years of this organization the principal activities were the making of surgical supplies and sewing various articles and the furnishing of money to provide Christmas cheer. The members worked closely with the Social Service, giving assistance on several occasions.

In 1943 The Auxiliary Store was founded in the main lobby of the old building with the two fold purpose of providing a service to patients and personnel and making money to be used for the benefit of the Hospital. The proceeds from this venture have made it possible to undertake some major projects for the Hospital, such as the installation of greatly needed additional plumbing facilities in South Building, completed last year at the cost of \$26,000.

#### LOOKING AHEAD

A hundred years may seem a short period of time in relation to the earth's age, but in a hundred years Hartford Hospital has come a long way since it was first conceived as a possibility by the people of the community at the May 2 meeting in 1854.

One can be rightfully astonished in contemplating the jump from the twenty patients cared for in that first year in a leased house in 1855; equally so is the contrast with the 45 patients in the first year of the new building in 1860, when one baby was born. The figure last year, with 33,221 patients admitted, reached the highest of all time and in addition 5,806 babies were born.

It is a far cry physically from the first brownstone building, with its two wards, one for men and one for

women, to our present sky-filling white brick structure with its capacity of 1,000 beds. The people of an earlier day could not have foreseen that hospitalization and medical service insurance plans would create such a demand for hospital care that there would be long lists of those waiting for admission. No longer is the hospital a place merely for the indigent with no homes or for the critically ill, and the length of stay has dropped from a tedious average of eight weeks to an amazing 7.6 days in 1953.

These facts and figures are the mere outward signs of the progress that has been made in the quality of medical and hospital care. This has been most noticeable in the past fifteen years. Many of the benefits have resulted from new drugs such as penicillin or from new diagnostic methods and new equipment for treatment. Some diseases that were formerly considered incurable or fatal are now in the non serious class, and others have diminished almost to the vanishing point.

As one looks ahead to the next century of service, one is certain there will be more astonishing changes. Perhaps by 2054 the present building itself will have become obsolete, and give way to some new, more functional structure. Research will be the weapon with which new conquests will be made, and through this field of endeavor Hartford Hospital will become a better place than ever before for the recovery of patients. And if a measure of peace can be obtained, the world will be a better place in which to live.

## THE PLACE OF TOBACCO IN THE ETIOLOGY OF LUNG CANCER

ERNEST L. WYNDER, M.D., *New York*

## THE INCREASING INCIDENCE

There now appears to be general agreement that at least part of the observed increase in the incidence of lung cancer is real.<sup>1</sup> Incidence data serve as a helpful clue in the evaluation of environmental factors suspected of influencing cancer development. Several points are of special interest concerning the incidence of lung cancer.

1. Age specific death rate for lung cancer has been increasing rapidly and nearly universal throughout the western world during the past three decades. (A notable exception is Iceland, where a recent autopsy series showed lung cancer to rank ninth in frequency among male cancer deaths.<sup>2</sup>)

2. The increase has occurred predominantly in the male, although an increase is also observed in females.

3. Lung cancer incidence reaches a peak towards the end of the sixth and beginning of the seventh decade of life and then declines.<sup>3</sup>

4. Lung cancer occurs more commonly in urban than in rural areas.<sup>4</sup>

5. The increase in lung cancer has taken place primarily among the epidermoid and anaplastic types of cancer.

If any environmental factors found to be associated with lung cancer are to be regarded as causative, they must, at least in part, be able to account for the observed incidence pattern of the condition. We shall, therefore, try to evaluate the compatability of the various exogenous factors considered to play a role in the development of lung cancer in the light of the observed incidence.

## EPIDERMOID CARCINOGENESIS

The increase in lung cancer has involved primarily the epidermoid and its related anaplastic types of

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## SUMMARY

This report is an evaluation of the present evidence relating smoking to the development of primary cancer of the lung. The author discusses various points both for and against such an association and concludes that an association between smoking and lung cancer must be regarded as established. The experimental evidence establishing cigarette tar as a mouse carcinogen is reviewed. It is emphasized that the significance of this observation does not lie in strengthening the human evidence linking smoking to lung cancer but rests chiefly in giving us a working tool to identify and possibly isolate carcinogens in tobacco tar. Possible preventive measures against lung cancer are also emphasized.

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cancer. It has long been noted that epidermoid cancers in animals rarely occur in sites not exposed to some type of specific irritation. Epidermoid cancer of the lung in mice, for example, is very uncommon.<sup>5</sup> Similar animal observations have been made for cancer of the skin, oral cavity and esophagus. Epidermoid cancer of the cervix is also very rare in animals, except in special genetic strains.

Parallel experience is at hand for man. Cancer of the scrotum is the classic example in human oncology, though other skin sites show similar relation to exogenous carcinogens. Cancer of the cervix rarely occurs in virgins.<sup>6</sup> Epidermoid cancer of the tongue, oral cavity and larynx appears often related to some form of extrinsic irritation.<sup>7</sup> In view of this background it should not be surprising that in the devel-

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opment of epidermoid lung cancer, extrinsic agents might also play a role.

This thought does not suggest that only exogenous carcinogenic factors are needed for epidermoid cancer to occur. Without doubt intrinsic factors are of basic importance, since otherwise all persons exposed to extrinsic carcinogens would develop some type of epidermoid cancer. Yet present evidence strongly suggests that extrinsic factors play an important role in the over-all development of epidermoid cancers and that, in their absence, many of these cancers might not develop.

#### CLINICAL-STATISTICAL STUDIES

Prior to statistical studies on exogenous factors in lung cancer, several clinicians had expressed their views. As early as 1912 Adler suggested tobacco as a possible factor in the development of lung cancer.<sup>8</sup> In the United States Ochsner has long felt, because the curves of increased incidence of bronchial carcinoma and the sale of cigarettes are roughly parallel, that tobacco plays an important role in the production of bronchiogenic carcinoma.<sup>9</sup> It is admittedly hazardous to rely chiefly on clinical impressions, but nevertheless, if observed by cautious and experienced investigators, such impressions do serve as a clue, or at least a starting point for more thorough clinical-statistical investigations.

The first significant, though small, studies were published by Lombard in 1928 and by Mueller in 1939 and demonstrated a positive association between smoking and lung cancer.<sup>10,11</sup> No study of a large enough number of cases to be convincing was published until 1950. Since then, however, twelve separate studies in four different countries have been made.<sup>12-25</sup>

In the study of Wynder and Graham all of the suspected exogenous factors were studied. It was thought that only in this manner could one determine whether a given variable was of primary, secondary, or no significance. Control patients of the same age and economic distribution as the lung cancer patients were selected. In view of the obvious sex difference in the incidence, the male and female data were analyzed separately. Finally, because of suspected differences in etiology of the epidermoid lung cancer and the adenocarcinomas, a separation of these histologic types was undertaken.

Though the data suggest a few occupations with higher than expected frequency of lung cancer, the majority of the patients with lung cancer had indus-

trial exposures which were similar to those of the controls.<sup>26</sup> The few occupations found to have an apparent high frequency of lung cancer, such as painters, wood workers, metal and gasoline workers, even in addition to the classical exposures to industrial agents such as arsenic, radioactive dust, chromate, asbestos, and nickel, involve too few people to account for the universal increase in lung cancer. Similar conclusions have been drawn by Kennaway and by Doll and Hill.<sup>27,28,18</sup> Previous lung diseases were not found more commonly among the lung cancer patients, except for chronic cough (bronchitis), which may be due to the greater use of some extrinsic agent among the lung cancer patients as compared to the control patients. Doll and Hill also conclude that previous lung diseases are of no etiologic significance in the development of lung cancer.<sup>18</sup>

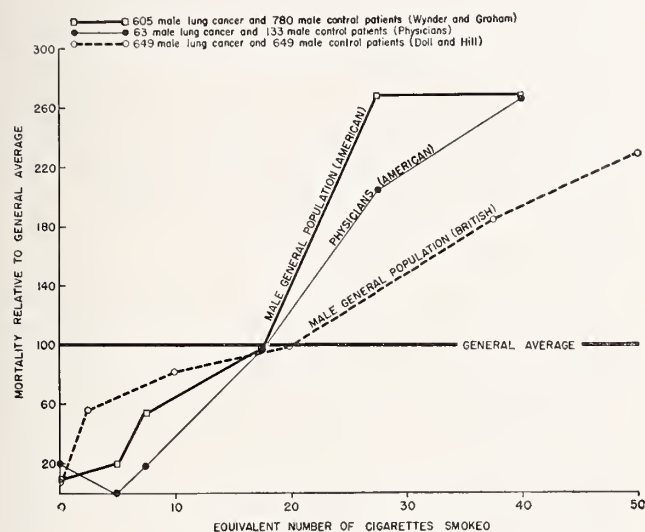
On the other hand the data show a strong association between smoking and lung cancer (Table 1). The results show significantly fewer non and light smokers among the lung cancer than among the control patients, while the ratio between the two increases in favor of the lung cancer group with increased smoking habits. These data include interviews conducted by the house staff of the Barnes Hospital Chest Service and have been added to the data reported previously.<sup>13,26</sup> During the same period of our investigation, Doll and Hill independently carried out a similar study in England.<sup>17</sup> Their study, extended to cover 1,465 lung cancer patients, showed similar results.<sup>18</sup> These studies reveal the risk of developing lung cancer to increase with the amount of tobacco smoked (Graph 1). Graph 1 also in-

TABLE I  
PER CENT DISTRIBUTION OF 870 MALE PATIENTS WITH EPIDERM-  
MOID, UNDIFFERENTIATED, OR UNCLASSIFIED BRONCHIOGENIC  
CARCINOMAS, AND 780 MALE CONTROL PATIENTS OF SIMILAR  
AGE AND ECONOMIC DISTRIBUTION, ACCORDING TO TOBACCO  
CONSUMPTION OVER A 20 YEAR PERIOD

SMOKING CLASSIFICATION*	LUNG CANCER PATIENTS	CONTROL PATIENTS
Total	870	780
Less than 1	1.6	14.6
1-9	2.6	11.5
10-14	9.2	19.0
15-20	35.1	35.6
21-34	30.8	11.5
35 or more	20.7	7.6

\*Equivalent number of cigarettes per day. One cigar has been arbitrarily treated as the equivalent of 5 cigarettes and a pipeful as 2½ cigarettes.

cludes the results of a study done on American physicians. This study almost duplicates the results obtained for lung cancer patients of the general hospital population.<sup>23</sup>



GRAPH 1

A positive association between smoking and lung cancer has now been shown in twelve recent, separate studies, covering more than 6,000 lung cancer patients. It has been stated that some doubt may be thrown on all of these studies because they differ in degree of association found. In this respect it must be realized they differed basically in the kind of interviews used. Some of them, for instance, were based on more or less routine hospital records, whereas others were made by specially designed interviews. The studies also differed as to smoking classifications and the types of tobacco used. Finally, they differed in type of lung cancer cases, with only a few studies insisting on histologic proof.

In view of these differences it is perhaps surprising that all showed a definite association between smoking and lung cancer. The studies by Doll and Hill and by Wynder and Graham showed especially close agreement. Levin has calculated the per cent of lung cancer attributable to smoking and found it to be in some studies as low as 56 per cent, and in others, such as those by Doll and Hill and by Wynder and Graham, as high as 90 per cent.<sup>29</sup> Even if we were to accept only the lower value of association, it seems still high enough to warrant our utmost attention.

In a recent study from the National Cancer Institute by Sadowsky, Gilliam and Cornfield, 477 lung

cancer cases were statistically analyzed as to their smoking habits against a suitable number of controls. These data in turn were compared to the other reported lung cancer surveys.<sup>25</sup> The authors concluded that, in view of the fact that so many different investigators, using different groups of lung cancer patients and control groups, all arrived at similar conclusions, it must be assumed that the association between lung cancer and smoking is real. In a recent symposium on lung cancer sponsored by the WHO and UNESCO, the association between smoking and lung cancer was also regarded as established.<sup>1</sup> *The New England Journal of Medicine* in a recent editorial considered present "evidence of an association between cigarette smoking and lung cancer so strong as to be considered proof within the everyday meaning of the word."<sup>30</sup>

#### TYPE OF TOBACCO

Recent interpretations of available data have underplayed the role of cigars and pipes in the development of lung cancer as compared to that of cigarettes. It is indeed true that the cigarette smoker appears to have a greater chance to develop lung cancer than the cigar or pipe smoker; yet the chance of the latter two is also significantly greater than that of a nonsmoker as shown in Table 2.

TABLE 2  
MORTALITY RATES FROM LUNG CANCER AMONG DIFFERENT TYPES OF SMOKERS

TYPE OF SMOKER	ESTIMATED ANNUAL MORTALITY PER 100,000	
	AMONG PHYSICIANS*	AMONG GENERAL POPULATION†
Nonsmoker	10	4
Smoker: Total	60	58
Predominantly:		
Pipe	40	16
Cigar	24	22
Cigarette	84	70

\*Data from Reference No. 23

†Data from Reference No. 13

These data show the importance of studying all types of smoking in an analysis of the effect of smoking on lung cancer. The reasons for the apparent greater correlation of cigarette smoking with lung cancer are not entirely clear. The greater practice of inhalation among cigarette smokers might account for some of the difference. The possibility that cigarette smokers are more likely to be heavy



users of tobacco than are cigar and pipe smokers must also be considered. Cigarette tobacco may be prepared somewhat differently from that used for cigars and pipes. Finally, it may be that cigars and pipes filter certain tar particles more thoroughly than do cigarettes. There is no present evidence that cigarette paper is carcinogenic to man. In view of the positive correlation of cigar and pipe smoking with human lung cancer the evidence suggests the carcinogenic factor to be a part of the tobacco itself. At any rate, an inquiry about cigar and pipe smoking must be an integral part of any tobacco history.

#### SEX RATIO

There has been a remarkable change in sex ratio in lung cancer over the past few decades. In 1912 Adler's report gave a ratio of 3 males to 1 female. Some of the more recently collected lung cancer series have given sex ratios as high as 24 to 1.<sup>31</sup> If the sex ratio were given only for epidermoid lung cancer the sex ratios would be even more predominantly male. A survey by Moersch and McDonald gave a ratio of 25 to 1 for epidermoid lung cancer and only 3 to 1 for adenocarcinoma of the lung.<sup>32</sup> The increasing male sex ratio strongly suggests the responsible factor to be an agent to which males have been exposed more and over a longer period of time than women. In this respect it has been often stated that women smoke as much as men do today. In view of the cancer age and the long latent period of cancer induction the smoking habits of the young women have no effect on the present sex ratio. In a study of female controls in the cancer age at the Barnes Hospital we found that about 80 per cent were nonsmokers and that but very few of these women had smoked heavily for at least twenty years.<sup>13</sup> The present sex ratio is therefore quite compatible with the long-term smoking habits of the two sexes. On the other hand, there is no evidence that women who smoke are resistant to lung cancer. Some rise in lung cancer, as stated previously, is also noted among women. And females with lung cancer, at least of the epidermoid type, show a positive association with smoking.<sup>13,18</sup>

#### DIFFERENTIATION OF CELL TYPES

Our data continue to suggest adenocarcinoma of the lung to be less closely associated with smoking than the epidermoid type. Among nineteen male patients with lung cancer who were nonsmokers, five had adenocarcinomas, a higher proportion of

this cell type than could be expected from its usual frequency. In female lung cancer patients no association between smoking and the development of adenocarcinoma could be found. Data by Doll and Hill and by Breslow suggest a similar result.<sup>18,20</sup> At any rate it seems important to separate histologic types in environmental surveys and to bear in mind that present evidence on the basis of such surveys and differences in sex ratio support the belief that adenocarcinoma of the lung has a different etiologic background from epidermoid lung cancer.

#### INCIDENCE PEAK OF LUNG CANCER

The lung cancer incidence curve reaches its peak during the late fifties and the early sixties and then declines.<sup>2</sup> In detailed incidence studies from Denmark, Clemmesen points out that the incidence peak of lung cancer among males in Copenhagen is among those born in 1885, while among those born in provinces it is 1880, and in farm areas it is 1875.<sup>33</sup> These data suggest to Clemmesen that such differences might be explained by an agent that came into being at different times in these areas. The fact that cancer occurs less frequently in the oldest age groups is compatible with an agent introduced newly into our civilization some thirty to forty years ago. The fact, too, that the younger cohort groups have an increasingly higher incidence of lung cancer suggests that this agent became more and more widely used by the younger generation. Tobacco habits, particularly cigarette smoking, are compatible with the cohort pattern of lung cancer observed. Clemmesen writes: "The differences in crude mortality rate for cancer of the lung between Copenhagen, provincial towns and rural areas may be ascribed to a delay in onset of the carcinogenic influence of about eight years for provincial and about ten years for rural areas. Thus, there is no reason to assume any carcinogenic influence of atmospheric pollution as far as Denmark is concerned."<sup>33</sup>

#### URBAN-RURAL DISTRIBUTION

Lung cancer occurs more commonly in cities than in rural areas. In the United States the lung cancer incidence among males was about twice as great in cities as in rural areas in 1945.<sup>4</sup> A similar difference is found in England; in Denmark the difference between Copenhagen and rural areas is about twice that great. Because of these differences, air pollution has been suggested to play an important role in the development of lung cancer.<sup>34</sup> The following points

are to be considered. The air pollution factor cannot alone account for the changing and present sex ratio of lung cancer. It cannot account for the cohort pattern since air pollution would affect all age groups at the same time, nor for the fact that an increase in lung cancer is now also being noted in rural areas.

In the evaluation of urban-rural ratios in lung cancer one must also consider that lung cancer patients from rural areas may come to the cities to be treated; consequently, those deaths may artificially increase the ratio by being recorded as city population.

At least some of the greater incidence of lung cancer among the urban population seems real. However, before we can incriminate air pollution, we must study the possible effect of other factors associated with city life. Doll and Hill studied tobacco habits of urban and rural population groups in England.<sup>18,35</sup> They found about twice as many nonsmokers among the farm population; there were fewer cigarette smokers and relatively more pipe smokers in the rural than in the urban population. Differences in smoking habits could, therefore, partially account for the observed differences in incidence. In a more recent study, Doll calculated that a nonsmoker in a city does not have any greater chance to develop lung cancer than a nonsmoker in a farm area.<sup>36</sup>

These statistical calculations again emphasize the importance of studying all possible factors before deciding that one given factor is etiologically or even statistically significant.

THE INCIDENCE OF LARYNX CANCER

It has been repeatedly asked why cancer of the larynx has not increased as sharply as lung cancer if smoking is a factor, since larynx cancer has also been found to be associated with smoking.<sup>12,25</sup> The following points are to be considered:

There has been an increase in the morbidity of larynx cancer in the United States, though not as marked as for lung cancer.<sup>37</sup> In view of the higher survival rate in larynx cancer, morbidity data rather than mortality data should be used to compare lung and larynx cancer incidence.

Incidence data on larynx cancer do not reflect the possible changing ratio of intrinsic and extrinsic lesions. The former may be more closely influenced by smoke inhalation. In India, where betel and tobacco chewing is more prevalent than cigarette

smoking, extrinsic larynx cancer is predominant. Further studies in this field must sharply divide the two types of lesions because of possible differences in etiology.

Other environmental factors which may influence larynx cancer may play no role in the development of lung cancer. Excessive alcohol consumption and certain dietary deficiencies may be of etiologic significance, at least in the extrinsic type of larynx cancer.<sup>7</sup>

In view of the considerations listed, further studies along the lines suggested above are necessary.

EVALUATION OF CLINICAL-STATISTICAL ASSOCIATION

In view of the fact that clinical-statistical data are often poorly prepared, assembled and analyzed, the medical profession has long doubted the value of purely statistical associations. Even well planned and conducted statistical studies may have inherent errors that could lead to erroneous conclusions because of certain statistical fallacies.<sup>38</sup>

Several possible inherent errors have been mentioned to account for the differences found in the lung cancer studies as far as smoking habits are concerned. The following are more frequently stated:

**Patient Bias:** It has been suggested that lung cancer patients over estimate their smoking habits. If this were the case, individuals with other chest diseases should do the same. Our data for chest service patients other than those with lung cancer revealed the same smoking habits as the controls.<sup>13</sup> Doll and Hill demonstrated that patients suspected of having lung cancer and later found to have another disease had the smoking habits of the control group.<sup>18</sup> The far less frequent association of smoking with adenocarcinoma of the lung also suggests that patient bias could not account for the observed differences between the lung cancer and control groups. It is therefore difficult to see that an over-estimation by the lung cancer patient could account for the correlation found.

**Interviewer Bias:** Several interviews among the various retrospective studies have been designed to keep the interviewer from knowing the patient's diagnosis. The results of such "blind interviews" were in line with the so-called "open interviews." Thus, interviewer bias could not account for the observed differences in smoking habits of lung cancer and control groups.

**Sampling Bias of Lung Cancer Patients:** It may be



proposed that a lung cancer patient who smokes is more likely to come to a hospital than one who does not. For this to occur we would have to assume that a smoking lung cancer patient has a different symptomatology from a nonsmoking one. Smoking lung cancer patients may more frequently have a history of bronchitis which brings them to a hospital. While such an individual might conceivably come to a hospital earlier than a patient that does not have a history of chronic cough, it is hard to believe that a nonsmoking lung cancer patient has the kind of symptoms that keep him from the attention of any physician. Furthermore, we have not clinically observed any different symptomatology in nonsmoking lung cancer patients from those in the smokers, provided we are comparing the same histologic types. A reasonable explanation for the assumption that nonsmoking lung cancer patients do not enter hospitals has not yet been given.

**Sampling Bias of Controls:** Many of the recent studies took great care in checking their controls for equal age, economy and place of residence, resulting in carefully weighted controls. Control patients, however, have mostly been hospital patients, and it may be argued that such patients do not reflect the general population. It is also possible that the general population smokes less than the general hospital population; thus, the differences between the lung cancer patients and the general population controls would be even greater. Mills and Porter presented some evidence in this regard, indicating less smoking among the general population.<sup>39</sup> The fact that other diseases may also be associated with smoking may account for this difference between the hospital controls and those of the general population. This difference, however, would magnify the lung cancer-tobacco correlation.

#### ETIOLOGIC ASSOCIATION

After re-examining the methodology of an environmental cancer study, reviewing the statistical associations found and searching for statistical fallacies, one asks next: How do the data agree with the available incidence pattern and concepts of pathogenesis of the cancer site being studied?

If no obvious fault can be found with the study, if the study is in agreement with other studies in the field, and if the found associations can explain, at least partially, the observed incidence rates, one can have confidence that the association is real and possibly causative.

The statistical correlation of smoking to lung cancer is also believed causative because of the following considerations:

The data are compatible with:

1. The noted universal increase of lung cancer in the western hemisphere. (The exception of Iceland may be in line with the fact that the per capita consumption of tobacco in that country in 1945 was only as high as in England in 1920.)
2. The changing and predominant male sex ratio.
3. The "cohort pattern" of lung cancer.
4. The urban-rural ratio of lung cancer.
5. The observation that an increase in lung cancer incidence is also starting among females.
6. Our current concept of epidermoid carcinogenesis.
7. The fact that the association cannot be readily explained on any other basis.

The fact, then, that the tobacco data are in agreement with these factors adds considerable weight to the belief that tobacco, especially cigarettes, is of etiologic significance in the production of lung cancer. Such a correlation does not, of course, exclude the possibility that other factors may be of equal or even greater importance in the development of lung cancer.

#### THE EXPERIMENTAL APPROACH

##### PREVIOUS DATA

Experimental work on possible carcinogenic effects of tobacco tars date back to 1900 and has been recently summarized.<sup>40</sup> Compared to work done with coal tars, the efforts with tobacco tar are relatively insignificant.

Roffo reported cancer induction in rabbit ears after tobacco tar application. Similar experiments by Sugiura and Flory could not confirm these data, although the latter obtained many papillomas.<sup>41-43</sup> Most of these studies were carried out with distilled tobacco tar. It has been pointed out that the resulting temperature conditions were not the same as in human smoking, and that, therefore, the data are not comparable. The majority of workers using mice as experimental animals also used distilled tobacco tars. Their combined studies resulted in the production of seven cancers of the skin in animals.

Inhalation studies with tobacco smoke have so far not produced any true bronchiogenic cancers in animals, though the development of pulmonary

adenomas is said to have increased through such procedure in susceptible animals.<sup>44</sup>

PRESENT DATA

In view of the increasing clinical evidence associating smoking with lung cancer, the experimental phases of this problem are now being investigated more extensively. In 1949 Wynder, Graham, and Croninger began an experimental investigation designed not to confirm or deny the human evidence, which must stand on its own merit, but rather to identify possible active carcinogens in tobacco smoke.<sup>40</sup> The tar solution used was obtained from cigarettes smoked in a manner simulating human smoking habits as closely as practically possible. The temperatures of the burning cigarettes were the same as those encountered in human smoking. A popular brand of cigarettes, smoked intermittently, was used. The resulting smoke was condensed in flasks immersed in dry ice. The tar was then dissolved in acetone and about 40 mgm. of the resulting solution applied to the backs of CAF<sub>1</sub> mice three times a week for a period of two years. The control mice were painted with acetone alone.

After eight months of painting, the first papilloma was noted in the tarred group and after twelve months, the first cancer. At the end of the study 59 per cent of the tarred group developed papillomas and 44 per cent carcinomas. Two of these cancers have been transplanted for nine and thirteen generations, respectively. No lesions were noted among the controls.

This experiment establishes cigarette tar as a carcinogen, at least to mouse epidermis. The long latent period and the fact that not all of the mice developed skin cancer suggest that this tar is not as potent as some other mouse carcinogens. We must consider, however, that the carcinogen(s) in the tobacco tar may be dilute.

The reason for the greater productivity of cancers in our study compared to previous experiments is not clear. It may be due to the fact that the tar was prepared in a manner simulating human smoking habits, that the tar was not denicotinized, and that the animals were painted for a long period of time. It must also be considered that the strain of mice used might have been especially susceptible to skin cancer formation.

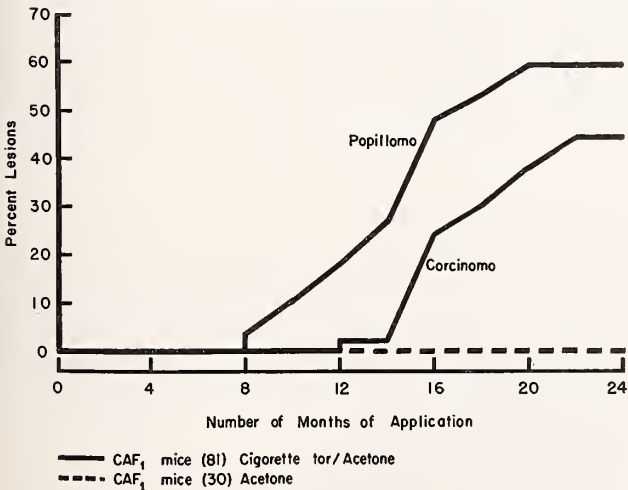
SIGNIFICANCE OF ANIMAL DATA

It may well be asked what significance such animal data have on the human cancer problem. A thorough discussion of this question involves the foundation of our entire cancer research program. Our concepts of carcinogenesis, as well as of chemotherapy of cancer, are closely bound to work carried on with experimental animals. As we review the history of cancer research, we note examples of a close similarity between human and animal data and others that show them to be at variance. When animal data coincide with human data, then, I believe, more significance may be attached to the meaning of the animal data.

In this respect it must be emphasized again that the experimental tobacco tar studies were carried out because of the human evidence already at hand. Without the human experience already available, the animal data would lose much of their significance.

The present mouse data do not influence the proof at hand linking smoking to lung cancer in man. The mouse skin is not like the bronchial epithelium—though they both represent epithelial tissue. The mouse skin test cannot give definitive proof for a human carcinogen, although it has long been used as a reliable tool for testing of carcinogenic materials and although historically, as in the coal tar and petroleum studies, a close correlation between animal and human data has been established in regard to epidermoid carcinogenesis. In view of this background and in view of the human data already available, the animal data must be considered, not as a proof for the human experience, but as a tool with which to work towards the isolation and identifica-

FIRST GROSS APPEARANCE  
OF PAPILOMAS AND CARCINOMAS  
ALL CARCINOMAS PROVED HISTOLOGICALLY



GRAPH 2



tion of carcinogenic agent(s). At this time we can only assume, on the basis of the combined human and animal data, that these carcinogens are the same for man and for mice.

#### THE CARCINOGENS

At the present we do not know the nature of the carcinogenic element(s) in tobacco tar. Favoring the theory of specific carcinogenesis over the non-specific one as far as extrinsic factors of irritation are concerned, we suspect specific carcinogen(s) in tobacco tar.<sup>40,45</sup> Arsenic is present in tobacco smoke, but available human and animal data suggest that the arsenic cannot be responsible significantly for either set of data.<sup>46</sup> We suspect that tobacco tar contains a new carcinogen or perhaps a number of subthreshold carcinogens. Present combined chemical and biological efforts carried out in various laboratories are being directed toward their identification.

#### FUTURE STUDIES

Future studies expanding on the problem of the correlation of tobacco and cancer involve clinical as well as continued laboratory efforts. Retrospective clinical data are perhaps no longer needed, since a sufficient number of studies presented quite similar data and conclusions. The so-called "forward studies" being carried out by Hammond and Horn on general population, by Dorn on U. S. veterans, and by Doll and Hill on British physicians will be of interest because they offer a somewhat different approach from the retrospective studies and have other inherent difficulties from the retrospective studies. These studies will be able to give us a good idea of the relative risk of lung cancer among different types of smokers. Early results from the British study indicate that "In the first twenty months, a number of deaths have been recorded due to lung cancer among doctors for whom details of the previous smoking histories are available. From the knowledge of the smoking histories of all the doctors who replied, mortality rates can be calculated for different levels of tobacco consumption—making allowance for the variation of smoking habits with age. Whilst the deaths are few, the calculated mortality rates are extremely unreliable, but as far as they go they entirely support the results recorded previously."<sup>47</sup>

Future studies will also involve a close surveillance of incidence data, which should involve particularly the expected increase of lung cancer in women, the

continued increase among males and the changing cohort distribution of lung cancer. The studies must determine whether the tobacco data continue to be compatible with such changing incidence data.

Perhaps the greatest effort must be placed on animal experimentation. Skin tests must be continued to determine the carcinogenic fraction(s). Expansion of such tests to other animals, as is being done on rabbit skin and dog bronchial mucosa, seems worth while, but perhaps not essential if we believe that animal data chiefly serve as a research tool to isolate the carcinogen(s). With this in mind, experiments with monkeys seem too costly and time consuming.

Studies involving bronchial mucosa seem worth while, especially from the academic point of view. Bronchopleural fistulae in dogs have been painted for over two years at Washington University. The long latent period and apparent resistance of some of the higher animals to tumor formation serve as a handicap.

Inhalation studies directed toward producing true bronchiogenic cancers involved the difficulty of getting a sufficient amount of smoke into the animals' lungs to compare with the amount smoked by man upon deep inhalation. While such inhalation studies are of interest and should be explored, they play no essential role in affecting the human data, nor do they lend themselves very easily to identification procedures directed towards determining active carcinogen(s). Animal data should be directed primarily towards the identification of such agents by the quickest, most economical, and most practical means.

A long and difficult road lies ahead, but just as in the coal tar and petroleum studies, a final answer must be obtainable. It is hoped that more and more investigators will join in this search, a search which we hope will lead to the identification and possible removal of carcinogenic substances from tobacco tar.

#### PREVENTIVE MEASURES

If we agree that tobacco plays a significant role in the development of lung cancer, proposed measures of prevention must be partially directed along this line. Two measures lie at hand: moderation of smoking habits and removal and reduction of carcinogen(s) from tobacco.

Moderation of smoking habits is, of course, a matter for each given individual. A teaching program directed in this line would be difficult because

of the basic human belief, "It can never happen to me." This thought is too deeply entrenched in our minds to significantly influence smoking habits of the general population, though recent events seem to suggest that some such curtailment will result.

The removal of actual carcinogen(s) from tobacco tars, on the other hand, would, if feasible, be the most far reaching. Current studies involving fractionation of tars and testing tobaccos grown in various parts of the world are directed towards determining the nature of these agents. The possible value of filters must also be studied. So far it is not known whether a given filter can remove any carcinogen(s) from tobacco smoke. Extensive work along these lines is urgent.

#### THE OUTLOOK

We are aware that cancer is a disease of multiple causes, some of which are endogenous and some of which may be exogenous. We also realize that other exogenous factors may play a role in the development of lung cancer, including some industrial agents, and that air pollution may be a cofactor. We know that epidermoid cancer of the lung may occur in the absence of a smoking history, though this is exceedingly rare, particularly if we exclude the cases of occupational exposures. We also know that not all who smoke develop lung cancer and that, as in all other diseases, the factors of internal resistance come into play.

While realizing the importance of other factors in the development of lung cancer, we must also admit that we do not comprehend many of these factors. Therefore, it seems, we must concentrate on those factors that we understand today. The tobacco factor is such a factor. In developing preventive measures, we must employ those that are available, that we understand, that are most practical, and that involve the greatest majority of our population.

Lung cancer is already very common today. In England it now accounts for 40 per cent of all male cancer deaths between the ages of forty-five and fifty-four and for 25 per cent of all male cancer deaths. Statisticians agree that the incidence will continue to increase, while at the same time the mortality from lung cancer continues to be alarmingly high. Because of the anatomic distribution of lung cancer, an earlier and more successful treatment will prove most difficult, unless we develop an entirely new concept of cancer therapy. It is thus

that we must rely chiefly on preventive measures as our greatest hope against this disease.

Preventive measures and principles have played a great role in the history of medicine by virtually eliminating some of the most deadly diseases. This was achieved when not all phases of development of the given diseases were understood. In our fight against primary cancer of the lung, these principles of prevention may some day bring forth similar success.

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## TREATMENT OF ACUTE AND CHRONIC RENAL INSUFFICIENCY

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## SUMMARY

Recent advances in the treatment of acute renal failure consist of preventive measures based on our current concept of its pathogenesis and supportive measures based on our knowledge of its natural history. We have learned that life is compatible with weeks of anuria and that we have methods of controlling fluid, calorie and electrolyte needs during the period of total renal functional impairment.

Radical measures, such as the use of the artificial kidney, peritoneal lavage and replacement transfusion, are recommended by some for the treatment of the patient with acute renal insufficiency, but the weight of evidence, in our opinion, favors the more conservative therapeutic regimen presented in this discussion.

Recent advances in the treatment of chronic renal insufficiency consist of attempts to prevent diseases that progressively destroy renal parenchyma by the use of antibiotic and chemical therapeutic agents and to reverse such diseases, once established, by the use of hormones.

Since we cannot alter the course of the underlying disease in patients with chronic uremia due to advanced renal disease, the aim of therapy is symptomatic relief and attempts to achieve this aim should be conservative.

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The evidence that the pathologic changes are limited to the lower nephron, however, is not conclusive. Oliver, MacDowell, and Tracy<sup>15</sup> re-examined this problem and concluded that the term "lower nephron nephrosis" is a misnomer because changes may occur in any portion of the tubule from its origin at the glomerulus to the collecting tubule.

ACUTE and chronic renal failure occur in the course of many diversified disease states. Treatment of patients with these diseases comprises extensive medical and surgical therapies directed at removing or reversing the causal factors. This discussion will not attempt to cover this rather large subject but will be limited for the most part to an evaluation of modes of therapy that aim to support the patient until recovery from the primary disease occurs and to relieve manifestations of renal functional impairment.

There are physiological adjustments in patients with chronic uremia which are not present in acute renal failure that affect the choice and manner of applying therapeutic procedures. Because of this fact and because prognosis, which also affects choice of treatment, is different, acute and chronic renal insufficiency will be discussed separately.

## ACUTE RENAL FAILURE PICTURE

Abrupt onset of renal functional impairment occurs in such renal diseases as acute glomerulonephritis, accelerated or malignant phase of hypertensive disease, and bilateral focal cortical necrosis; occasionally in such systemic diseases as subacute bacterial endocarditis, lupus erythematosus disseminatus, and periarteritis nodosa; in diseases due to noxious agents which produce changes in various sites of which the kidney is one; and in bodily injuries which induce a renal response. An attempt to classify some of these latter diseases was made on the basis of a common renal lesion. Lucké<sup>12</sup> introduced the term "lower nephron nephrosis" to include the pathologic changes found in such conditions as traumatic and postoperative shock, crush syndrome, blood transfusion reaction, thermal burns, and intoxication by arsenic, carbon tetrachloride and sulfonamides, in which the significant clinical findings are great diminution in urinary volume and uremia.



This irregularly distributed lesion consists of a disruption in the continuity of the tubule due to necrosis of cells and fracture of the basement membrane. The mechanism suggested for the production of this lesion of acute renal failure is anoxia of the tubular cells. Patients in shock develop anuria and uremia, and it is believed that the renal lesion results solely from circulatory insufficiency. In experimental hemorrhagic shock, moderate blood loss for short periods produces decreased renal blood flow and reversible impairment of renal function, whereas severe blood loss for longer periods produces anuria and irreversible uremia. These clinical and experimental observations indicate that decreased renal blood flow, which occurs in a variety of disease states, can produce renal injury. Other mechanisms which may contribute to functional impairment in acute renal failure are direct injury to the proximal convolution by a nephrotoxic agent, renal edema or obstructing casts in the collecting tubules.

#### METHODS OF TREATMENT OF ACUTE RENAL FAILURE

Treatment of severe oliguria or anuria, the outstanding manifestation of acute renal failure, is the major therapeutic challenge in these patients.

Cardiac and cerebral symptoms occurring in the course of acute renal insufficiency are treated in the usual manner. Morphine sulfate, digitalis, and oxygen are used in the more acute instances of pulmonary edema. Transitory encephalopathic symptoms require no special treatment; if they persist or recur, 100 cc. of 2 per cent solution of magnesium sulphate may be given intravenously as an initial dose.

The treatment of the anuric patient is discussed as a single problem with the understanding that the underlying disease must also be recognized and treated.

Attempts to treat persistent severe oliguria or anuria fall into the following categories: to prevent or reverse the mechanism responsible for anuria by such procedures as transfusion of blood, spinal anesthesia and renal decapsulation; to increase urine flow by the use of diuretics; to control concentrations of urea and other constituents of the plasma by such procedures as the artificial kidney, peritoneal lavage, replacement transfusion, and intestinal intubation; or to support fluid, calorie and electrolyte balance.

#### BLOOD TRANSFUSIONS

It is believed that avoidance of prolonged periods of peripheral circulatory failure may prevent anuria.

Blood transfusions should be used in the treatment of extensive thermal burns, blood loss and trauma to prevent shock and, at the first sign of shock, to diminish its duration and extent. When shock and anuria appear together, as in mercury intoxication, administration of blood or plasma is indicated.

#### SPINAL ANESTHESIA

Spinal anesthesia has been used in the treatment of anuria on the assumption that renal vasoconstriction is responsible for the decrease in urinary volume and with the hope that renal denervation might relieve this constriction. There is no experimental evidence that indicates that denervation would be of value after anuria has occurred, and the evidence as to the clinical efficacy of this procedure is not convincing.

#### RENAL DECAPSULATION

Renal decapsulation in the treatment of anuria is based on the assumption that there is an increase in intrarenal pressure, that this pressure acts to decrease or inhibit renal blood flow and glomerular filtration, and that decapsulation decreases intrarenal pressure. Proof of these assumptions is lacking and clinical experience on the whole has been disappointing.

It is not our practice to use either spinal anesthesia or renal decapsulation in the treatment of the anuric patient.

#### USE OF DIURETICS

Attempts to increase urine volume in anuric patients by the use of diuretics not only fail but may be injurious. Such osmotic diuretics as hypertonic glucose fail probably because anuria is associated with severe depression of glomerular filtration so that only the smallest increment in urine flow could be expected as a result of increasing osmotic pressure of the small amount of tubular urine. In addition, tubular degeneration and necrosis permit passive back diffusion into the particular capillaries, since the tubular cells no longer act as a barrier membrane obeying laws of concentration gradients. By the same token, mercurial diuretics are also ineffectual, since only small amounts of mercury would reach tubule cells and the number of functioning cells is considerably decreased. Furthermore, failure of renal excretion of mercury would act to maintain a high plasma concentration and add the danger of mercurialism.

Emphasis has been placed on disturbances of the electrolyte pattern of the blood in anuric patients and various procedures have been employed to keep

constituents of the plasma as close to their normal values as possible. It is possible to vary the concentration of urea and other dialysable constituents of the blood by passing a large volume of heparinized blood through coils of cellulose acetate tubing or between two cellophane sheets immersed in fluid containing various dilutions of electrolytes, by transperitoneal lavage effected by the introduction and collection of fluid through surgically placed intra-peritoneal catheters, or by replacement transfusion. These procedures have been recommended by some in treating patients with persistent anuria associated with acute reversible renal disease, the procedure purporting to maintain life until subsidence of renal pathology is followed by spontaneous improvement in renal function. Plasma concentrations of urea, sodium, calcium, potassium and other constituents are used as indices for instituting and guiding the treatment.

ARTIFICIAL KIDNEY

Merrill<sup>13</sup> has recently reviewed what he believes are the indications and contraindications for the use of the artificial kidney. He states that "in acute renal insufficiency, the procedure, if properly employed, may be a valuable adjunct to conservative management and occasionally in acute spontaneous potassium intoxication have a distinct advantage over other methods of treatment." He discusses contraindications to hemodialysis and makes the following points:

1. Abnormality of plasma concentrations is not an indication unless accompanied by clinical symptoms. If the clinical state cannot be closely related to the chemical imbalance, the use of the artificial kidney has no value.
2. Heparinizing the patient in order to prevent coagulation of the blood may cause or aggravate hemorrhage into such sites as the gastrointestinal tract and brain. Merrill cites their experience of hemorrhage occurring during the use of the artificial kidney and continuing after termination of hemodialysis, even though the clotting time is restored to normal.
3. Patients with acute glomerulonephritis, particularly with severe hypertension should not have hemodialysis since hypertension may be aggravated and convulsions may occur following the procedure.

In evaluating indications for the use of the artificial kidney we should consider the natural history of anuria and the results of conservative management. Reversible or irreversible tubular injury has occurred

in patients with acute renal failure before oliguria and anuria appears. In this sense, treatment of anuria is always late and until measures are available that reverse tubular cellular changes, therapy can, at best, be supportive during that period in which renal epithelium undergoes a remarkable spontaneous reparative process. Death of patients with anuria is more closely related to the associated disease than to failure of the kidney to excrete urine. Although the number of days from onset of anuria to spontaneous diuresis is extremely variable in acute renal failure, in general diuresis occurs from the second to the sixteenth day. Stock<sup>21</sup> reported anuria of six to fifteen days' duration (average about ten days) in twenty-two patients who survived. He observed a patient with complete uretero-pelvic obstruction due to bilaterally aberrant renal arteries and veins in whom simple supportive measures sustained life for fifty consecutive days. Strauss<sup>22</sup> cites instances in which patients were reported as surviving prolonged periods of complete anuria lasting from twenty-eight to forty-five days. We observed a patient who died on the thirtieth day of anuria. Pratt<sup>17</sup> observed a ten months' old child who recovered after eleven days of anuria and we<sup>18</sup> have observed spontaneous diuresis and recovery after nine days of anuria in an eight year old child. Spontaneous recovery, it appears, can occur after more than two weeks of anuria and life is compatible with anuria of six weeks in the adult and at least ten days in children. Following spontaneous diuresis, renal function progressively increases from its very depressed level and generally shows full recovery within a few weeks or months. It is not known whether a prolonged period of anuria may result in chronic renal disease.

Most patients will recover from anuria in the course of acute renal failure unless there is excessive protein intake or tissue breakdown, excessive fluid or electrolyte administration, or serious associated disease. Stock<sup>21</sup> reported a survival rate of eighty per cent in fourteen patients treated by conservative measures; Muirhead, Vanatta and Grollman<sup>14</sup> reported eighty-five per cent survival in twenty-seven patients, and Bull<sup>4</sup> reports a recovery rate of seventy-eight per cent in nine anuric patients. Stock points out that only one death in fifty-two patients with acute renal insufficiency treated conservatively was due to retention of solutes and that this fatality today might be prevented by the use of cation exchange resins.



We are now ready for a general statement on the use of the artificial kidney in the treatment of patients with acute renal insufficiency. The artificial kidney is not recommended because spontaneous diuresis with recovery can occur after more than two weeks of anuria, spontaneous diuresis usually occurs before the end of the second week, and life is compatible with anuria of six weeks' duration. Furthermore, the results of conservative therapy are excellent, whereas there are uncontrollable dangers when the artificial kidney is used. This indictment of the artificial kidney as a therapeutic procedure in the treatment of the anuric patient is not meant to discourage further experimentation in this field and it may be that indications for its use under rare circumstances eventually may be established. Peritoneal lavage and replacement transfusion are not recommended in the treatment of patients with acute renal insufficiency on the same grounds.

Now let us look at the conservative therapeutic regimen which we recommend in the treatment of the patient with acute renal failure. The most promising results in the management of the anuric patient are obtained by measures that rigidly control fluid, calorie and electrolyte balance.

#### CONSERVATIVE TREATMENT OF ACUTE RENAL FAILURE

Just enough water should be administered by mouth or vein to cover insensible water loss. Insensible water loss under favorable circumstances averages 750 cc. to 800 cc. per day, water of oxidation will supply roughly 300 cc., leaving a water requirement of 500 cc. To this basic figure of 500 cc. of water we add the amount of fluid lost from the body in urine, excessive sweat, diarrhea or vomitus to compute the daily requirement. The daily requirement of the anuric patient for water must also be considered in the light of other factors that affect water balance and that will vary from patient to patient, such as activity, body temperature, metabolic rate and the environmental temperature and humidity. The patient should be weighed daily so that a gain in weight indicative of excessive fluid administration will be detected. Excessive fluid administration produces an increase in blood volume, subcutaneous edema, and may cause pulmonary edema and death. The difference between the correct amount and too much fluid is not great; it is estimated to be less than a few hundred cc.'s a day. I can remember the day when postoperative anuric patients were given six to ten liters a day.

#### SUPPLYING CALORIES

Administration of glucose supplies caloric needs and by preventing excessive breakdown of body protein and fat reduces accumulation of ketones, potassium, phosphate and sulphate to as slow a rate as possible. Furthermore, when glucose is converted to glycogen it causes intracellular deposition of potassium, thus supplying additional protection against hyperkalemia. The problem of determining the optimal caloric intake of the patient has not been fully resolved. At one extreme some investigators believe that 100 Gm. of glucose per day is adequate and that no further protein sparing results from increasing carbohydrate intake above this figure. Borst<sup>3</sup> in Holland and Bull<sup>4</sup> in England on the other hand recommend intake in excess of 2500 calories a day which they achieve by giving such fats as butter and peanut oil. It is difficult to decide this question from the limited number of published case reports comparing the results of low and high calorie regimens, when one considers the number of factors that have to be controlled, such as associated disease, metabolic needs and the severity of the renal lesion. It has been our practice to supplement the calories obtained from 100 Gm. of glucose by administering additional fat. We have used peanut oil as a source of added calories but find that it produces diarrhea in some patients. Bull, who suggested the use of peanut oil, had no such difficulty in his early experience but recently wrote that he is also having similar trouble and believes that different batches of oil vary in their effects. We have also used a "hard sauce" which some patients have been able to ingest for three or four days, made by saturating butter with granulated sugar and adding brandy, whiskey or vanilla extract for flavoring. In patients with anuria of more than four or five days' duration, however, it is usually necessary to provide fat and carbohydrate in a form that can be administered through a naso-intestinal tube. If vomiting occurs, feeding should be given by way of a tube in or below the jejunum. Prepared fat emulsions\* are available now for oral feedings. We have found that no set feeding schedule can be adhered to but that it is necessary to vary the diet from patient to patient and even from day to day in a single patient suffer-

\*Lipomul-oral (Upjohn Company) contains forty per cent peanut oil and ten per cent dextrose, each cc. provides four calories; Ediol (Schenley Laboratories) contains fifty per cent coconut oil and 12.5 per cent sucrose, each cc. provides five calories.

ing a prolonged period of oliguria. We do not have data that indicate that by increasing the caloric intake less body protein is metabolized and the rate of increase in blood urea concentration is slowed, but it is our impression that the patients are subjectively and objectively better when on the higher caloric intake. One patient who received 2500 calories a day in the form of emulsified peanut oil and was relatively asymptomatic appeared as well on the twenty-eighth consecutive day of anuria as at the onset. We do not believe that caloric intake is the primary factor that determines the natural history of the anuric patient. It is important, however, that the calories be derived from sugar and fat and not from protein.

#### ELECTROLYTE CONTROL

The third aspect of the conservative therapy of patients with acute renal insufficiency has to do with electrolyte and pH control. The serum concentrations of potassium, sodium, chloride and bicarbonate are used as guides in electrolyte administration. No electrolytes are given unless indicated by clinical manifestations of electrolyte deficit or excess, by low plasma levels, or by known electrolyte loss through the gastro-intestinal tract or skin.

One of the serious threats to patients with acute renal failure is potassium intoxication. Hoff, Smith and Winkler<sup>11</sup> demonstrated that death occurred regularly in anuric animals following ureteral ligation or nephrectomy as a result of potassium intoxication. The clinical manifestations of hyperkalemia cannot always be readily identified and confirmation by electrocardiogram and serum concentration may be necessary. However, serum potassium concentration levels may be misleading. There may be poor correlation among symptoms, electrocardiographic changes and plasma concentration of potassium in patients with acute renal failure. This fact has suggested that other factors such as acidosis and sodium deficit may contribute to potassium intoxication.

It has been our experience that significant increases in serum potassium concentration do not occur if no potassium is given to the anuric patient in food or fluid, if excessive body protein breakdown is prevented by adequate caloric feeding, and if blood pH is controlled by administration of bicarbonate. Should abnormal accumulation occur, the cation exchange resins may be used. Oral administration is preferred to rectal installation but it has been demonstrated that the latter is effective. Use of cation

exchange resins containing sodium salts must be carefully controlled since the danger of increasing body concentration of sodium exists. A second method of removing potassium employs the intestinal mucosa as an exchange membrane. A Miller-Abbott type tube is introduced into the small intestine and irrigation with potassium-free solution carried out. This procedure must also be carefully controlled to prevent excessive loss of electrolytes or excessive absorption of water.

#### PREVENTION OF ACIDOSIS

Acidosis is another threat to the patient with acute renal insufficiency. Here again, it has been our experience that adequate caloric intake decreases the rate of accumulation of phosphates, sulphates and other acid metabolites. Should excessive retention of acid occur, as indicated by clinical symptoms and significant quantitative changes in the serum, oral or parenteral bicarbonate may be cautiously administered. Oral administration of 10 to 20 Gm. of sodium bicarbonate in the first twenty-four hours is the average dose in attempting to treat acidosis. Hypertonic sodium bicarbonate, five per cent, has been used intravenously but raises the problems of excessive sodium administration and increased osmolarity of the blood. Furthermore, since the kidney is not functioning in these patients it is necessary to use caution to avoid the real danger of excessive alkali administration. The urine cannot be used as a guide since bicarbonate administration will either fail to alkalinize the acid urine observed in acute renal failure or a lag period will warn too late of overcorrection. Respiratory alkalosis has been reported following correction of metabolic acidosis in patients to whom sodium lactate was given or who were treated by dialysis using the artificial kidney.<sup>24</sup>

Plasma sodium concentration in patients with anuria is extremely variable and the advisability of seeking to correct hyponatremia is still a debated question. If any free water is administered, hypertonic saline has no advantage over normal saline, and its administration may be extremely dangerous. But we are not certain that sodium should be given to all patients in whom plasma sodium concentration is decreased. An occasional patient will show a significant hyponatremia without apparent cause, there being no excessive loss of sodium from the skin or gastro-intestinal tract. It is not known to what extent hyponatremia represents a shift in body sodium from the extracellular fluid to other sites, but it is known



that the administration of sodium to patients before diuresis occurs may result in pulmonary edema. Administration of hypertonic saline to patients with decreased plasma sodium concentration will be on a safer and more rational basis when more data are available on the osmolarity of blood in such patients.

During the recovery phase careful observation is necessary to avoid the danger of excessive electrolyte loss. Tubular function remains impaired after glomerular filtration begins to improve and excretion of such electrolytes as sodium, chloride and potassium may be excessive. Hypochloremia has been observed by Thorn<sup>23</sup> and Burwell, Kinney and Finch<sup>6</sup> during the postanuric, early diuretic phase. Callaway and Roemmich<sup>7</sup> reported the development of hypokalemia in a patient anuric for fourteen days following exposure to carbon tetrachloride. Symptoms and electrocardiographic changes associated with decreased potassium serum concentrations were reversed on the seventh day after diuresis started by intravenous administration of 5 Gm. of potassium chloride in one liter of normal saline given over an eight hour period. It is therefore necessary in this phase of recovery to continue to observe the patient for symptoms and signs of electrolyte loss and to follow serum concentrations. The danger of overloading with fluid and salts continues to exist in the postanuric, diuretic phase and indications for their administration must be carefully evaluated. Bull<sup>5</sup> studied discrete renal functions in patients with acute tubular necrosis and found that the duration of the early diuretic phase ranged from five to eighteen days with a mean of twelve days. Patients with acute renal failure, therefore, require close observation for at least two to three weeks following the onset of diuresis.

#### TREATMENT OF CHRONIC RENAL INSUFFICIENCY

Treatment of chronic renal insufficiency may be considered first from the prophylactic point of view, that is, the prevention or reversal of those diseases that progressively destroy renal parenchyma, and second, management of patients with chronic uremia.

#### PREVENTION

Our information concerning prevention and early reversal of renal disease is of fairly recent origin and inadequate for definitive conclusions. The preventive treatment of glomerulonephritis is primarily the elimination of respiratory and other infections. If it were possible to treat infection at the very onset,

antibiotics might be able to influence the development and intensity of the immunological response. However, once infection is clinically evident, treatment of that infection by antibiotics would not in theory be expected to break the chain of events that leads to glomerulonephritis. Should it be shown, however, that the incidence of glomerulonephritis can be decreased by early and adequate treatment of hemolytic streptococcal infections, the role of antibiotic therapy in prophylaxis will be apparent. The results obtained in decreasing the incidence of rheumatic fever by prompt and adequate antibiotic therapy suggest that this approach may be applicable to glomerulonephritis. Similarly, it is interesting to speculate on whether the widespread use of antibiotic and chemical agents early in the treatment of urinary tract infections will reduce the number of patients with atrophic pyelonephritis who develop chronic renal insufficiency.

#### DIET, NITROGEN MUSTARD, HORMONES

Dietary treatment is thought by some to influence the course of renal disease. It has been suggested that protein restriction, by limiting the work of the kidney, might decrease the chances of acute renal disease progressing to the chronic state. Addis<sup>1</sup> recommended a low protein diet in acute renal disease (0.2 Gm. protein per kg. of body weight), consisting chiefly of cereals, sugar and fruit juices, supplemented by vitamins, iron and calcium, followed by small gradual increases in protein content up to 0.75 Gm. protein per kg. In chronic renal disease, even with hypoproteinemia, proponents of low protein therapy advise a diet containing 20 Gm. of protein a day. We do not believe that protein restriction has a beneficial effect on the course of renal disease and therefore recommend no restriction during acute renal disease and normal protein intake in the chronic uremic patient.

Nitrogen mustard ( $\text{HN}_2$ )<sup>8,2</sup> and steroid hormones<sup>9</sup> have been used to induce remissions in patients with well established renal disease. It appears that these agents may induce diuresis, decrease proteinuria, and increase glomerular filtration rate, renal blood flow and maximal tubular excretory capacity. This combination of effects has been interpreted by us as indicative of return of glomerular and tubular function towards normal and suggests that these agents may be capable of inducing a remission in the course of such chronic renal disease as the nephrotic stage of glomerulonephritis. It is not known whether

this form of therapy will affect the ultimate outcome of the disease but the fact that it is capable of reversing the manifestations of renal disease establishes these agents as promising tools.

Goldring, Baldwin and I have found that ACTH and cortisone are more effective than nitrogen mustard in that the hormonal effects on the manifestations of glomerulonephritis are quantitatively greater and have a higher frequency of induced remissions. It appears at this time that ACTH and cortisone are both effective. We administered cortisone in dosage ranging from 100 to 400 mgms. a day in four doses and ACTH in dosage ranging from 100 to 200 mgms. a day in two doses, and ACTH in gel, 1 mgm. per pound of body weight given once a day. Effective dosage is variable and this problem is still under study. Treatment periods ranged from ten to twenty-eight consecutive days and in some patients serial courses of therapy were continued over periods of months.

We have administered forty courses of ACTH or cortisone to fifteen patients with glomerulonephritis and a temporary remission was induced in about half of the patients. In no patient did we observe any untoward renal or systemic effects that did not spontaneously reverse themselves. In three patients the repeated administration of  $\text{HN}_2$  or ACTH and cortisone over a period of months was associated with what appears to be a permanent remission. The post-treatment follow-up period in these three patients ranges from one to four years during which time proteinuria and other manifestations of renal disease have been absent. We have not concluded that these patients were cured as the result of therapy employed since there are at least two alternative explanations. First, the induced remissions may not have been casually related to the ultimate cure since these patients might have gone on to spontaneous cure; and second, the induced remissions contributed to, but were superimposed on what might have been a benign course of glomerulonephritis. In other words we do not know whether  $\text{HN}_2$  or the steroids had no effect on the cure, were responsible for the cure, or helped make cure possible in patients whose disease was such that cure was possible. It is our opinion at this time that ACTH and cortisone should be used in the treatment of patients with glomerulonephritis except for those in the terminal hypertensive and uremic stage of the disease. Nitrogen mustard is not recommended in the routine treatment of patients with renal disease.

In the management of patients with chronic renal insufficiency we are limited in what we can expect to accomplish since in the present state of our knowledge there is no way to alter the course of the underlying renal disease. The aims of therapy, then, are symptomatic relief and supportive treatment, and attempts to produce these results should be conservative.

I shall outline only briefly our opinions on the methods of treating patients with chronic renal insufficiency since they are in agreement with those generally held.

#### OUTLINE OF THERAPY

The asymptomatic patient with chronic renal failure is permitted to lead a fairly normal life. If deficiency or excess of an ion is known to be injurious, an attempt at correction is made. Correction of disturbances in the electrolyte pattern of the blood, however, is treatment directed at manifestations and not at the disease. Consequently, such correction alone will not alter the basic disturbance which led to the abnormal serum concentration. It must also be remembered that, in giving fluids and electrolytes to patients in uremia, there is the danger of heart failure due to sudden increase in blood volume following the administration of too large a volume of fluid parenterally, and the danger of rapid shifts from acidosis to alkalosis following the administration of alkali because of the kidney's inability to offset changes in pH.

Dietary management is difficult at times because of anorexia and nausea. We do not limit protein in the presence of elevated blood urea concentration and recommend an intake of about 60 Gm. a day unless there are other indications for limiting protein, such as hyperkalemia. There are those, however, who believe that protein intake should be restricted to 20 Gm. a day in patients in chronic uremia. It is difficult to evaluate the effect of varying the amount of protein intake on symptoms or course in patients in the terminal stage of renal disease since spontaneous changes occur frequently in the last few months of life. It is our opinion that limiting protein intake, except when indicated in rare instances, is of no value and that adequate protein intake may maintain the nutritional status of the patient without harming him.

Therapy directed solely at reducing abnormally elevated blood urea concentration is not warranted in our opinion. Acute elevation of blood urea expe-



perimentally and significant degrees of azotemia over a period of years in patients with chronic renal disease indicate that azotemia does not produce symptoms. Nor is there reason to believe that one can prolong the lives of patients by maintaining decreased levels of blood urea. Smith<sup>20</sup> states that the retention of urea itself "does not account for the toxic manifestations and physiological disturbances of renal failure." Golding and I<sup>10</sup> varied the blood urea concentration of a patient in the terminal uremic stage of chronic glomerulonephritis from 52 to 276 mg./100 cc. by increasing protein intake from 13 to 238 Gm. a day. Although these observations covered a relatively short period of time, the patient was without complaint during the periods of low blood urea concentration as well as during extreme elevation.

The blood urea concentration is variable in patients with uremia since they frequently have symptoms such as anorexia, vomiting and diarrhea, all of which affect the physiological factors that determine its level, namely, urine volume, urea production, and glomerular filtration rate. This variability tends to obscure the relationship between blood urea and urea clearance, but our data<sup>10</sup> demonstrated an inverse relationship. In 103 observations in patients with hypertensive disease or glomerulonephritis on a constant protein diet and with urine volume always above 1.5 cc. per minute, elevation of blood urea begins with the first reduction in the urea clearance. There is no "renal reserve" in the excretion of urea. As long as the patient's nitrogen metabolism and body water remain constant and he is in nitrogen equilibrium, the blood urea will vary inversely with the urea clearance from its initial decrease.

Once the patient has reached the terminal stage of renal disease and the urea clearance (and filtration rate) are noticeably decreased, and are fairly stable at about 5 cc. per minute, variations in blood urea concentration are no longer a quantitative indication of renal functional impairment and since the level of blood urea at this time will be determined primarily by such factors as protein intake, the absolute level of the blood urea is without prognostic significance.

The patient in uremia is frequently dehydrated and adequate fluid intake must be prescribed. It is necessary to give as much fluid by mouth in a twenty-four hour period as the patient loses in the same period by way of skin, lungs, kidneys and

gastro-intestinal tract. If the parenteral fluid is necessary, a solution of 5 per cent glucose in 0.85 per cent sodium chloride is valuable in combatting dehydration and hypochloremia.

Chemical disturbances of body fluids vary from patient to patient and treatment must be individualized. The concentrations of plasma electrolytes are used to supplement the clinical picture for guidance in fluid and electrolyte administration. Yeomans and Stueck<sup>25</sup> have re-emphasized the work of Singer and Hastings<sup>19</sup> that demonstrated the limitations of plasma CO<sub>2</sub> content and CO<sub>2</sub> combining power in evaluating acid-base balance in patients in uremia and recommend the use of whole blood buffer base and CO<sub>2</sub> tension. Sodium bicarbonate, orally or parenterally,  $\frac{1}{6}$  molar lactate intravenously, or transfusions are administered cautiously to correct acidosis. Sodium is not limited unless congestive heart failure is a threat to the patient's life. Hyponatremia occurs frequently in chronic uremia and sodium should be administered to such patients to guard against exaggeration of the depression of glomerular filtration. Failure of the kidneys to substitute ammonia and hydrogen ions for base explains in part the frequent combination of acidosis and hyponatremia.<sup>16</sup> Respiratory alkalosis may occur when metabolic acidosis is corrected by the administration of sodium lactate.

An attempt to combat the effects of hypocalcemia is made by increasing the intake of milk in the diet and administering calcium salts. Aluminum hydroxide is given to decrease absorption of phosphate from the gastrointestinal tract in patients with hyperphosphatemia.

Potassium intake should be reduced in those patients who retain this cation excessively. However, retention of potassium to critical values is rare in chronic renal insufficiency, the probable explanation for this being the relative increase in potassium clearance in advanced renal disease. Should clinical manifestations and electrocardiographic changes indicative of hyperkalemia occur, correction may be attempted with intestinal lavage introducing potassium-free fluid by way of a Miller-Abbot tube. As in acute renal insufficiency, the cation exchange resins have been reported as effective in removing excessive potassium. Potassium bicarbonate is given to patients with manifestations of hypokalemia.

We do not use the resins in the treatment of edema in the presence of chronic renal insufficiency because their use exaggerates the acidotic trend.

There is no satisfactory treatment for the anemia of chronic glomerulonephritis which does not respond to iron or liver therapy. Transfusions are transitory in effect but when symptoms of anemia limit the patient's activity, transfusions are given as indicated.

Bromides and chloral hydrate by mouth or rectum are given for sedation in the terminal uremic stage. If restlessness and insomnia increase, morphine sulfate may be given. Paraldehyde administered rectally at intervals throughout the twenty-four hours is one of the more effective soporifics in uremia.

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## DYNAMICS IN PSYCHIATRY

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IT is a welcome experience to find myself in a place where dynamic psychiatry is familiar and accepted, where its principles are well established in the medical community. There is no need for me to take up your time with an exposition of such principles. I can turn at once to my dual topic: (1) Where did dynamic psychiatry originally come from? and (2) What changes in medical education may we expect as a result of the invasion of medicine by dynamic concepts?

Perhaps I should first say what I mean by dynamic psychiatry. I mean simply a psychiatry that keeps its sights always on motivation—one that never forgets the invisible, but vitally important, human drives, the powerful tensions and conflicts which shape our patients' conduct and decisions. Some of these hidden motivational factors a patient may know about and be able to talk to us about; but many of them appear on the surface only as signs and symptoms.

This is a psychiatry which is in line with the rest of medicine. It is interested in signs and symptoms, all right; but it is always much more interested in what these signs and symptoms represent. So, in dynamic psychiatry, we begin with a frank recognition that we cannot arrive at an understanding of the origins and the character of pathological behavior solely through what a patient remembers and recognizes, through what he is able and willing to verbalize.

Although in what follows I shall emphasize throughout the behavioral or psychological aspects of medicine, it goes without saying that all human activity involves physiological change, whether this activity is normal or pathological. But, just as it is possible to have normal behavior in a patient with definite tissue pathology, so also we must expect to find that pathological behavior does not necessarily mean—in fact, usually does not mean—that there is corresponding physiopathology. For example, what

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### SUMMARY

Dynamic psychiatry deals primarily with emotional and interpersonal problems of medicine. It has emerged as a medical science out of prescientific attempts to understand hypnosis and to use it therapeutically. The physician Mesmer made heroic use of it in the 18th century; but he failed because he was argumentative, theatrical and lacking in self criticism. Nearly a hundred years later a neurologist, Charcot, and an internist, Bernheim, rearoused medical interest in hypnosis. Freud, who originally used hypnotic therapy, studied with both men. Eventually he developed new methods and dynamic concepts of brilliant originality. He met opposition with more and more clinical material, and was himself one of his most severe critics. Twentieth century medicine has been gradually absorbing psychodynamic attitudes and methods. Now the behavioral sciences are doing the same. Medical contributions to behavioral science are not new. Some of the most important names in psychological history are those of physicians—Fechner, Helmholtz, Wundt, Janet, James, Pavlov and Freud. The new collaboration of medicine with behavioral science presents new problems, especially for medical students. General medical practice includes well over thirty per cent psychiatric problems. Medical students need preparation for this with a practical knowledge of normal personality and its genetic development, of emotional and interpersonal relationships in our swiftly changing social environment. As in Hippocratic times, emotional and personality problems belong to the whole of medicine.

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we call normal behavior in one culture, will in another culture be called definitely abnormal; but, of course, the physiological changes in the individuals of both cultures must be similar.

Now I am ready to go back to my first question: Where did dynamic psychiatry originally come from? I suppose it must ultimately have come from the ancient Greeks, since everything else seems to have started with the Greeks. But within modern times it has certainly come out of attempts to understand hypnosis and to use it therapeutically.

We still do not understand hypnosis too well; and its use in therapy is still greatly restricted. But even if hypnotism had turned out to be useless, which it is not, or even a hoax—which it certainly is not—its fruits in terms of modern medicine would still justify all the trouble it has caused, all the heat and the squabbling that centered around it for a century and a half.<sup>1</sup> A great deal of this controversy arose because of the magical claims that hypnosis depended upon personal magnetism; and some of the men who claimed this meant magnetism that streams out from a person's body, like the rays from a schizophrenic's "influence machine."

Interesting as this phase of prescientific thinking was, I shall have to pass swiftly through it, up to the point where it helped launch Sigmund Freud on his magnificent venture, which ushered in the modern age of psychodynamics. The first two centuries I can cover in a few sentences. In the sixteenth century we find that angry medical genius, Paracelsus, maintaining that ordinary magnets influence human bodies in the same way that the stars do. This was still an age of magic and astrology; but it was trying hard to become mechanistic.

In the seventeenth century we hit upon something that sounds a little more physiological, though it is actually more of the same old magic. The physician, van Helmont, came forth with the claim that a magnetic fluid, called "animal magnetism," radiates from a person's body. He said that this magnetic fluid could be turned at will upon other persons, so as to influence their minds and bodies. This is the doctrine of "personal magnetism," taken in a completely literal sense. It sounds exactly like what we call delusional thinking nowadays. But we must not lose sight of the prescientific times in which it occurred. Neither must we forget that this was a serious attempt to account for a real and important fact: the fact that people do influence one another, in ways they still do not completely understand, and to a degree that often seems magical even today. It is a sobering thought that some of the things we all take for granted and repeat, in the medicine of 1953, may well sound, two hundred

years hence, like the schizophrenic "influence machine."

A hundred years or so after van Helmont, toward the close of the eighteenth century, we come at last to the turbulent career of Dr. Anton Mesmer, who practiced first in Vienna, where there has been so much originality in so many fields, and then in Paris. Mesmer shared some of Paracelsus' talents. Among these was a talent for arousing virulent antagonism and keeping it alive. As a result of this he was virtually driven out of both cities. He died in Switzerland, an exile, when he was eighty-one. And right up to the end he was still intent upon justifying his faith in "animal magnetism" and in his own powers.

Early in his practice Mesmer followed Paracelsus to the extent of actually using magnets to stroke his patients with. But even with his many defects he remained still something of an empiricist; for he discovered that he could get the same results without the magnets, and he had the courage to discard them.

Was Mesmer completely off the track? Were his claims based on pure delusion? Not at all. It is the consensus today that he probably did treat neuroses successfully. He was unquestionably right in insisting, to the end of his life, that he had been able to induce demonstrable and rather extraordinary changes in his patients by his methods. Yet in the last analysis Mesmer was a failure. Why?

There are many possible answers to this question. I shall stress two. First, he wasted his major efforts in trying to force recognition from his many opponents and detractors; and second, he was never able to stand back and look dispassionately at his own procedures. He never succeeded in analyzing what he himself was doing; and he never understood just what it was that he was trying to treat. He could not distinguish the hocus pocus in his therapeutic methods from what was sound and effective. Instead of examining what he was trying to do, with something approaching self criticism and scientific detachment, Mesmer appealed to showmanship. He tried to justify himself by the size of his practice and his vogue among the well to do in Paris. He was theatrical. He turned to publicity and insistent argument, instead of turning to the clinical facts. And through it all he clung to the old animal magnetism interpretation. So much for Mesmer, a remarkable and courageous man, but no scientist. His personal failings helped him along toward his ultimate defeat; and they in part accounted for the disrepute into which mesmerism quickly fell.



There was another rather stormy revival of mesmerism among British medical men in the 1840's; but it did not last. Even during the brief flare-up of interest and activity, however, a few advances were made. Mesmerism was given a new name by the Scottish physician, James Braid. He christened it *neurypnology*, which took it out of the "isms" and gave it a good, neural sound. (Our modern term, *hypnosis*, comes directly from *neurypnology*). Braid also gave the phenomenon a more acceptable explanation. The favorite mode of inducing hypnosis then was that of having the patient fixate an object well above the line of regard. Braid felt that the origin of hypnosis must be in a paralysis of the fatigued eyelid muscles, and a spread of this effect within the nervous system. Although this explanation was completely inadequate, it was at least phrased in terms that did not dishonor hypnosis. Braid later pointed out also the importance of suggestion in the induction of hypnotic phenomena.

After the 1840's, interest in hypnosis flagged again, until the great Charcot took an interest in it. He made a great contribution and a great mistake, both of which set the stage for the appearance of modern dynamic psychiatry. The great contribution was that he recognized striking similarities between hysterical symptoms and hypnotic phenomena. This enabled him to carry hypnosis one step further towards respectability. He formulated hypnosis in the same ways that he had already formulated hysteria, that is, in terms of reflexes, sensory processes and muscular movement. This new formulation, even though it was also inadequate, at least gave hypnosis a neurophysiological appearance. In such a guise, it finally gained full official acceptance as something genuine and worthy, so that anyone could show a frank interest in it without becoming suspect.

Charcot's great mistake was a natural one. He concluded from the striking similarities that hypnotic phenomena were always hysterical; and he therefore insisted that only hysterical patients could be hypnotized. This mistaken conclusion led to the now famous controversy between Charcot and Bernheim, professor of medicine at Nancy. This other man had seen and taken part in a great deal of hypnotic therapy (which Charcot had not); and he insisted that anyone could be hypnotized, and that therefore hypnosis was not a part of hysteria. The significance of Bernheim's claim is very great for modern psychiatry and psychotherapy. It made hypnosis and suggestion both normal phenomena,

and paved the way for an unlimited extension of hypnosis as a therapeutic procedure, and suggestion as an explanatory principle. Bernheim also made the important observation that suggestion in the waking state is similar to that in the hypnotic state. This, in a way, presages Freud's step in abandoning hypnosis for free association.

It was one of Charcot's students who managed to eclipse all of his predecessors and contemporaries in this field. This man was Sigmund Freud. One gets some inkling of Freud's industry from the fact that, during his stay in Paris and after he returned home, he translated two volumes of Charcot's writings from the French; and both before and after his short visit to Nancy, where he went to get the lowdown on Bernheim's work, he managed to translate two of Bernheim's volumes into German. But it was not his industriousness that distinguished Freud. He showed intellectual brilliance, daring originality, great erudition, and a spirit of scientific detachment.

It was Freud who took the loose threads of European psychiatry and psychology, and together with many of his own creation, wove an empirical fabric of great strength and originality. It is essentially Freud's fabric, as we all know, that has become the basis of dynamic psychiatry. And he is also a chief contributor to dynamic psychology, that is, to the psychology of motivation, drives, tension, conflict and the unconscious determination of behavior.

One of Freud's most revolutionary steps was the one he took when he abandoned hypnosis—which in his day had become one of the neurologist's standbys—and substituted for it the method of free association in the waking state. The couch and the talking were still there; but the hypnotic trance was gone. The story of what led Freud to make this change—the serious limitations of hypnotic therapy—has been told by him in his own autobiographical writings, and is too well known to bear repetition here. On the same grounds I shall pass over his equally revolutionary development of the empirical concepts of resistance, repression and the defense mechanisms, his founding of the new science of dream interpretation, and his courageous and insightful use of transference. Suffice it to say that today most of his basic conceptions have been taken over, not only by psychiatry but by other behavior sciences also.

And this brings me now to the questions I have been moving toward from the start: How can we account for the fact that psychodynamics has

finally succeeded in infiltrating psychiatry? And, why is it that the other behavior sciences are admitting psychodynamics today, when for so many decades they rejected such concepts out of hand?

I shall try to answer the first question first, because I think the answer to it is simpler and more obvious than the other.

Psychodynamics has infiltrated psychiatry largely because there was a vacuum in psychological medicine, a need for something more than description and classification. Dynamic psychiatry has simply moved in and filled the vacuum. If there had been a vigorous, effectual competitor in the field, dynamic psychiatry might have come much later, and probably in a somewhat different form. But there was no effectual competitor in the field. The wonder is that dynamic psychiatry did not move in long before it did.

For the relative slowness, the almost osmotic character of the process by which dynamic concepts have entered psychiatry, I have only an evasive explanation. It is that medicine was not entirely ready for them. The ideas were too original, too novel, too strange. Culturally, the Victorian and Edwardian world was shocked and repelled by some of the essentials of Freudian doctrine, which could not be watered down without destroying their validity: for example, the facts of infantile sexuality and the incest motive.

Even today, in our much less inhibited world, an interesting study of the osmotic acceptance of psychodynamics in medicine could still be carried out if anyone had the time, interest, expertness and money to do it. All over the United States and Canada we have medical schools. In these medical schools I am sure one could find every stage in the osmotic process, from indifference or indignant rejection to enthusiasm and finally to quiet acceptance into the body medical.

There were, of course, many factors hindering the advent of dynamic psychiatry in the universities besides the forces of cultural conservatism. One example will have to serve for the rest. The period of the rise of psychodynamics was also the period of the great triumphs of histological accounts of disease, of microbiology and the biochemical sciences. In this same period the sciences of interpersonal relationships must have seemed pale and ineffectual. No biologist of that day could have foreseen the advance which these have been making in recent years. The structural, physiological and biochemical sciences

were coming up in those days with unlimited good answers. No need was felt for interpretations of illness in behavioral terms; and no help was expected from such relatively undeveloped other fields. And here was Freud coming up with novel interpersonal and intrapersonal data, just as Mesmer had tried to do a century earlier; and Freud at first got the same kind of treatment that Mesmer did.

Then why did dynamic psychiatry succeed eventually, where mesmerism did not? For one thing, Freud always focussed on the basic problem of trying to explain why things happened as they did. He inquired of himself constantly as to why his methods worked or failed. For example, it was out of failures in hypnosis, which other practitioners accepted as inevitable, that he went on to develop the far superior technique of free association. The concept of the transference he similarly evolved from apparent failure. He was able to become deeply involved in methodology, and at the same time to maintain great detachment in relation to his own participation in the therapeutic situation. By such a process and with such attitudes he built up strong bulwarks of organized clinical fact. He showed himself quite capable of shifting his ground when, in the face of new evidence, his hypotheses turned out to be inadequate. He even had the courage to reverse himself at times.

Another reason why dynamic psychiatry took hold, where Mesmer had failed, is that Freud had the gift of enlisting the loyalty of others. This not only supplied him with able coworkers; it must also have helped him to persevere, without very much more academic and professional recognition than Mesmer got. Freud used his energies in treating patients, in studying clinical phenomena, in building and elaborating hypotheses—instead of wasting time and energy in trying to force his opponents to recognize and accept him.

It is, then, a simple historical fact that dynamic concepts, interpretations and methods (which have come directly or indirectly from Freud) have been gradually absorbed over recent decades, and are now in the process of being digested and assimilated. During this period medicine needed increasingly effectual explanations to match the growing recognition of neurotic and psychosomatic illness. No one in academic medicine had come up with really useful information about the patient's motivations, his unconscious needs, his fears, his sexual problems, his hates and conflicts. But these outsiders, with their psychodynamics, had for a long time devoted them-



selves to the clinical study of such problems, and to conceptualizing what they had found. They were ready.

So we find ourselves today in this newer phase of digestion and assimilation. There is mutual modification going on, between the dynamic point of view in psychiatry and the problems in the rest of medicine. A really effective and living psychiatry is developing in the medical schools and teaching hospitals, where our physicians of the future must be trained.

I come now to my second question: Why are the other behavior sciences also absorbing Freudian dynamics today? Here there has certainly been no vacuum. Psychology, to name one of them, has for decades been doing an extraordinarily effective job, both in theory construction and as an experimental science. What is the situation there? If it seems strange that medicine should have been invaded by physicians talking psychology, it must seem at first glance still stranger that psychology should be infiltrated by doctrines developed in clinical practice, and chiefly by medical men. Yet we find Boring, the foremost historian of experimental psychology, naming psychoanalysis as the chief source of dynamic psychology, and naming Freud as the greatest figure in contemporary psychology.<sup>2</sup>

Actually this situation is not so strange. It is rather in the tradition than out of it. The present-day mutual suspicion and defensiveness between psychologists and medical men is of very recent origin. It is to be hoped that it may be also short lived. Physicians have sometimes contributed importantly to the development of psychology. I mention the names of Fechner, Helmholtz, Wundt, Janet, James and Pavlov.

After all, it must be remembered that Freud in his revolt against the psychiatry of his day, was actually contributing a system of psychology to medicine. It seems likely that Freud was always closer to the main streams of psychological theory than he was to the medical thinking of his middle years. We know that he was a man of great erudition and breadth of interest. He must certainly have been influenced by the psychological atmosphere to which he was exposed.

I have mentioned that he translated Charcot and Bernheim from the French. But still earlier in his career he translated a volume of miscellaneous writings of John Stuart Mill from the English, which was published in 1880. This, according to Freud himself,<sup>3</sup> he did upon the recommendation of

Brentano, leader of the school of act psychology, under whom he also took six courses during 1874-76. These six courses indicate the early direction of his interests, since they are the only non medical work on his university record.<sup>4</sup>

Freud might well have begun to develop his own highly original style of thinking under the influence of Mill's writings and Brentano's courses. It seems justifiable to assume that a man of Freud's intellectual curiosity and thoroughness would not confine himself to just those essays of Mill which he himself was actually translating. Mill's thinking would certainly alert a student to problems of human motivation, and make it reasonable for him, when the need developed in his own later work, to develop and utilize such basic concepts as the pleasure principle and its derivative, the reality principle.

Brentano was himself noted especially for his doctrine that psychic phenomena are acts, that active ideas are directed upon objects and have intentionality, the objects "inexisting" within them. In this material it is not difficult to detect some possible sources of stimulation for the development of some of Freud's basic interests, perhaps even the later concepts of object finding and of introjection of the object. In 1874, the year when Freud began his studies with him, Brentano published one of his major works. In this book<sup>5</sup> he devoted an entire chapter to a detailed discussion of the concept of unconscious ideas, which he traced back as far as Thomas Aquinas. He begins the chapter with a defense of one sense of the paradoxical expression, "unconscious consciousness," and ends it by rejecting such uses of "unconscious" as those of Hartmann, Herbart and Lange. He cites and discusses Hartmann's "Philosophie des Unbewussten," Lange's "Geschichte des Materialismus," and to a lesser extent, Herbart's "Lehrbuch zur Psychologie," and his "Psychologie als Wissenschaft." Earlier in the book Brentano does battle with Maudsley's physiological interpretations. He quotes Maudsley's statement to the effect that the most important part of mental activity, the most essential process upon which thinking depends, consists in an unconscious activity of the mind.

I should like to speculate for a moment about the possible influence of Herbart upon the beginnings of psychodynamics. In the "Lehrbuch zur Psychologie," there is the notion of dynamic psychic conflict, crudely expressed but unmistakably there. Ideas, Herbart says, become forces when they resist one another. Resistance is an expression of force; it

occurs when two or more opposed ideas encounter one another. When an idea has been inhibited by another idea, it yields without being destroyed, by changing into a tendency. When the inhibition ceases, the idea by its own effort again makes its appearance in consciousness. All ideas resist suppression, submitting to no more of it than is absolutely necessary.<sup>6</sup> Herbart represents consciousness as relatively small, as insufficient for the large number of ideas which, therefore, must struggle with one another for the privilege of becoming conscious. Here are possibly some of the crude forerunners of our modern dynamic concepts of unconscious conflict, repression, latent thoughts and, perhaps, the "indestructible wish."

This is speculation; but I do not think it is idle speculation.<sup>7</sup> Psychodynamics undoubtedly has its primitive ancestors, just as relativity has. It seems at least possible that the early influences that stirred Freud's genius may be found in the psychological atmosphere surrounding Brentano in the middle 1870's.

But whatever its early psychological origins, twentieth century psychodynamics has developed as independently of academic psychology as of academic medicine. To dynamic psychiatry most of the psychologies of the 1910's and 1920's seemed as useless as geology or conchology. And to most psychologists of the same period psychodynamics seemed only a strange, isolated school of thought with an unintelligible vocabulary. The principal change in this situation has been brought about by American psychology, which had itself meanwhile matured and developed to the point where it needed more dynamic concepts than it had. The concepts of dynamic psychiatry were at first found to be useful, and later to be indispensable.

The history of this change is to some extent a history of the emergence of motivation, not as the property of one school or another, but as a dominant problem throughout the whole field of pure and applied psychology. There is no important development in psychology today that is not in some sense dynamic. All ongoing American psychology is taking serious account, in one form or another, of such concepts as drive, need, tension, conflict, goal or purpose, and the unconscious (or at least non conscious) determination of behavior. The important influence of the Yale group in contemporary psychology has come about in large part through its long preoccupation with these and other basic dynamic concepts.

For medicine, the rapprochement between dynamic psychiatry and motivational psychology is not an unmixed blessing. Like relatives returning home to live, psychology and the other behavior sciences come bearing gifts, but also presenting us with new problems. Dynamic psychiatry long ago extended its basic generalizations into the behavior sciences. It advanced hypotheses and drew conclusions about normal individual behavior, as well as about neuroses. It studied genetic development, family and group dynamics. It made hypotheses concerning social prehistory. It discussed value systems and the bases of cultural conflict. Some of these excursions, more or less tentatively begun, have led to relationships of a serious and enduring nature. Now the behavior sciences, with new dynamic insights, have succeeded in making new and vital contributions to our understanding of man in society and culture.

These are the "gifts" which we are now being offered by the behavior sciences, and which we are not prepared to take. So we come finally to a problem that I posed at the beginning of my talk: What changes in medical education will we have to make in the light of dynamic concepts? This is only another way of asking: "How shall we go about training the physicians of tomorrow?"

I wish I could finish up with a grand scheme that would solve this situation we are all facing—once and for all. But I cannot; and I doubt if anyone else can. Medical education has to grow. We can sometimes accelerate the pace; and if we are wise enough, we can sometimes help to give it new directions. But the process is still growth and development.

We all know, of course, that 30-40 per cent of our medical patients present us with psychiatric problems of one kind or another. And, if we include psychosomatic involvement, this high percentage must rise still higher. Even the psychiatrist has come to realize today that psychiatric problems are no longer his exclusive property, but belong to the whole of medicine. And this means, of course, that personality problems—emotional and interpersonal problems—belong to the whole of medical practice, and not to any one specialty. We must somehow find a way of preparing our medical students for these inescapable aspects of their medical work.

The medical student needs somehow to acquire expert knowledge of normal personality and the normal human environment.<sup>8</sup> He should certainly understand normal personality development—the characteristics of the normal infant, the child, the adolescent, the adult and the senescent. He would



then be able to anticipate, for example, the important effects of a particular stage of development upon a patient's reaction to illness—the difference in reaction to a traumatic illness, say at the ages of two years, fourteen, and thirty—or the difference in reaction to gastrointestinal disturbances in earliest infancy, in later infancy, and in adolescence or late adulthood.

We know that medical students should understand clearly the dynamics of early sexuality, of pubescent and adolescent attitudes, of family formation and parenthood. The statistical reports that are appearing these days are interesting and useful; but they are no substitute for the organized knowledge that our medical students need.

The medical student should understand the significance of status and role in American life—the difference between being a janitor, a skilled mechanic or an office manager, when it comes, say, to a fractured arm or impaired vision. It would help him greatly if he were prepared for the effects upon patients of the swift changes in social structure which are now going on, and for the effects of our shifting ethical and moral codes. He certainly needs to be aware of adolescent stresses, both from the adolescent's point of view and from that of the harrassed parents—the difficulties that arise constantly nowadays over the conflict between an adolescent's loyalty to his parents and his loyalties to his own age group. As we all know only too well, these problems are likely to come into the physician's office in the guise of sleeplessness, headache, loss of appetite, bowel irregularities, extrasystoles, or some other form of somatic protest—the signs and symptoms of a deeper, underlying stress.

Our dilemma is simply stated: Most of our medical students enter the clinical years quite unprepared for the emotional and interpersonal problems which they meet as soon as they begin work in medicine or surgery.<sup>9</sup> More than that, they often lack even the perspective they need for an understanding of dynamic concepts in medical practice. And so, quite unprepared, they come face to face with complex and sometimes urgent problems of reaction to organic illness, to trauma or disability. They meet an unreasonably prolonged convalescence in one patient, anxiety in another over the helplessness of being bedridden, fright in a third over the prospect of major surgery or of chronic disease. And in such situations they may have nothing to go on, excepting a little common sense, and whatever incidental

knowledge they may have picked up. This seems to me like facing a student with problems in modern cardiac surgery when he has no technical knowledge whatever of cardiac physiology and cardiovascular dynamics.

We need somehow to match the fine training the medical student gets in the anatomical, physiological and biochemical sciences, with equally sound training in the basic behavior sciences. And we need to arrange this so that these two kinds of interrelated training go on at the same time, from the very start of medical education. How this is to be managed without weakening the essential work in the present preclinical sciences is one of our greatest puzzles. This is, of course, not the psychiatrist's problem; it is yours and mine. I have no panacea to recommend and, as I have already indicated, I doubt if anyone else has a prefabricated solution, guaranteed to work. But until medical men have solved this problem, it will still be there, staring us in the face. And, in the end, I don't believe we can completely meet it without some help from the behavior sciences, to which dynamic psychiatry has given so much and from which medicine has so much to gain.

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## TRAUMATIC PERFORATION OF A MECKEL'S DIVERTICULUM

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## SUMMARY

A rare case of traumatic rupture of a Meckel's diverticulum is presented together with a brief resume of the literature on various interesting aspects of the diseases of Meckel's diverticulum.

## INTRODUCTION

Meckel's diverticulum is one of the more common anomalies seen on the surgical service of the average general hospital. This clinical entity has received considerable attention in the literature because it has the unusual ability for producing complex and atypical clinical patterns, which cannot be diagnosed with any great degree of accuracy. We have recently encountered a case of Meckel's diverticulum with perforation as a direct result of non penetrating trauma to the anterior abdominal wall. To our knowledge no case of this type has been reported in the literature. This case will be presented together with a brief review of the established facts concerning this anomaly.

## HISTORICAL FEATURES

Hildanus in 1598 first described a diverticulum of the small intestine. Four others, Cavater in 1671, Ruysh in 1707, Littré in 1742 and Morgagni in 1769, described similar diverticuli, before Johann Friedrich Meckel in 1815 accurately described the anatomy, embryology, and pathology of this congenital anomaly as we know it today.

## INCIDENCE

The incidence of Meckel's diverticulum as derived from various reports of autopsy material in the literature varies from 1 per cent to 2.5 per cent. Reports derived from laparotomy are generally lower. Harbin reported an incidence of 1.3 per cent in 507 laparotomies where it was carefully looked for.

The incidence is higher in males, the ratio ranging from 2-1 to 4-1 in several reported series. No ex-

planation can be given for this increased incidence in males.

## EMBRYOLOGY AND ANATOMY

Meckel's diverticulum results from incomplete obliteration of the Vitelline duct or yolk stalk which begins at about the fifth fetal week and is complete by the seventh week of fetal life. When this fails to occur then various anomalies develop. If no obliteration takes place then an intestinal fistula may result. Partial obliteration can result in a patent discharging sinus at the umbilicus or, in rarer instances, if either end obliterates leaving a patent middle portion, the accumulated secretions from the persistent duct wall form an enterocyst. The most common anomaly, the diverticulum, follows complete separation of the obliterated distal portion with persistence of the proximal end resulting in an outpouching of the small intestine, usually of the terminal portion of the ileum. However, it may be found to arise from other portions of the intestine. In 63 cases reported by Christie the diverticulum was observed to occur between 15 and 90 cms. from the cecum with an average distance of 50.6 cms.

This diverticulum differs from other diverticula of the small intestine in that it contains all the layers of the muscularis of the intestinal wall. It can vary greatly in size but usually averages from 2 cms. to 5 cms. in length.

Heterotopic tissue occurs in about 25 per cent of all Meckel's diverticula. Gastric, duodenal, jejunal, and pancreatic mucosa have been found in these diverticula. However, gastric mucosa is the most frequent and according to Shaltz occurs in about 16 per cent of all cases.

## PATHOLOGY

The pathological changes seen in Meckel's diverticulum may range from simple inflammation to neoplasm.

Hemorrhage is one of the more common pathological findings; this usually occurs with ulceration



caused by heterotopic gastric or pancreatic tissue. Perforation can follow ulceration or can also occur from inflammatory change. Several cases have been reported in the literature where perforation resulted from a foreign body. Hiller and Bernhard reported a case of inflammation and perforation by a tomato peel lodged in a Meckel's diverticulum. Williams in 1940 reported a case of Meckel's diverticulum in which a fish bone had perforated the wall and caused peritonitis.

H. N. Harkins collected 160 cases from the literature of intussusception due to invagination of a Meckel's diverticulum. Invagination of a Meckel's diverticulum can also cause partial intestinal obstruction. Cases of volvulus have also been reported.

This diverticulum has been found in various type of herniae. Watson in 1924 reported 96 cases in inguinal herniae and 34 cases in femoral herniae.

Benign and malignant tumors have been found to originate in Meckel's diverticulum. Nygaard and Walters reported twenty malignant tumors, fourteen of these were sarcomas and six carcinomas. A carcinoid tumor in a Meckel's diverticulum was reported by Paitler and Scotti in 1951.

#### DIAGNOSIS AND CLINICAL FEATURES

Only in those rare cases in which an umbilical fistula exists can the diagnosis be made with certainty preoperatively. Roentgenological examinations in the absence of a fistula are usually unable to demonstrate the diverticulum.

Rectal bleeding, if present, in the first three decades of life, offers the best clue to the diagnosis.

Some authors attempt the preoperative diagnosis of acute diverticulitis on the basis of persistent and repeated colicky pain, localized near the umbilicus with maximum tenderness and rigidity about one-half inch below the umbilicus, either to the left or right.

A history of melena or recent hemorrhage by rectum followed by acute peritonitis should arouse the suspicion of perforated ulcer of Meckel's diverticulum.

A complication such as intestinal obstruction can be readily diagnosed but in most instances the diagnosis of the diverticulum itself can be made only at the time of operation.

#### TREATMENT

The treatment is surgical, either by simple excision or by resection, depending upon the presence and

extent of the complications seen at the time of surgery. Incidental diverticulectomy is usually without mortality. When complications exist the mortality rate is high. Schullinger and Stout quote mortality rates of 40 per cent for acute inflammation, 30 per cent in peptic ulcer of the diverticulum, and 42.5 per cent in perforated ulcer. However, these statistics were compiled prior to the advent of the broad spectrum antibiotics. The use of these antibiotics definitely lowers the mortality rate. There are no recent statistics present in the literature on a significant number of complicated cases of Meckel's diverticulum that were treated by antibiotics. We feel certain that these mortality and morbidity rates would be reduced to about one-half or one-third of the figures set forth by Schullinger and Stout.

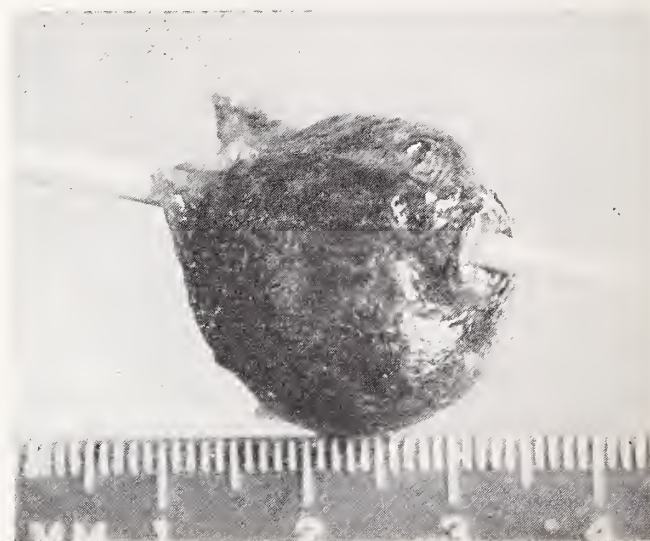


FIGURE 1

This specimen shows a probe passing through the resected end of the diverticulum and out through the perforation. There was no evidence of previous inflammatory reaction in the diverticulum.

#### CASE HISTORY

A 58 year old white male was admitted to St. Francis Hospital on September 17, 1953 with a history of having been struck across the lower abdomen with a one by four inch plank while trying to feed it through a circular saw. He had considerable pain in the lower abdomen and was forced to leave work and lie down. The pain became more severe and he had one episode of vomiting. Upon admission he stated that he had been unable to void since the accident which was about four hours previous.

Upon physical examination the patient appeared his stated age and was perspiring profusely with an ashen, pale complexion. Positive physical findings on examination were limited to the abdomen. There was a 2.5 cm. by 12 cm. area of erythema just above the pubic symphysis which was said by the patient to be the site of injury. There was marked spasm of the muscles of the entire lower abdomen and this

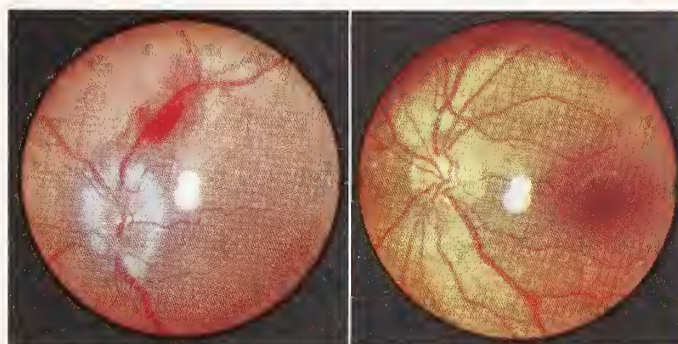


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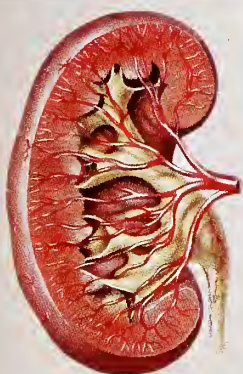


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\*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EOEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEGELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

C I B A





#### **ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES**

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin<sup>1</sup> found Pyribenzamine beneficial in 82% of 107 patients; Feinberg<sup>2</sup> noted relief in 82% of 254 cases; Gay and associates<sup>3</sup> in 76% of 51 cases; Arbesman and colleagues<sup>4</sup> in 84% of 106 cases. In a later study Arbesman<sup>5</sup> rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."<sup>6</sup> Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

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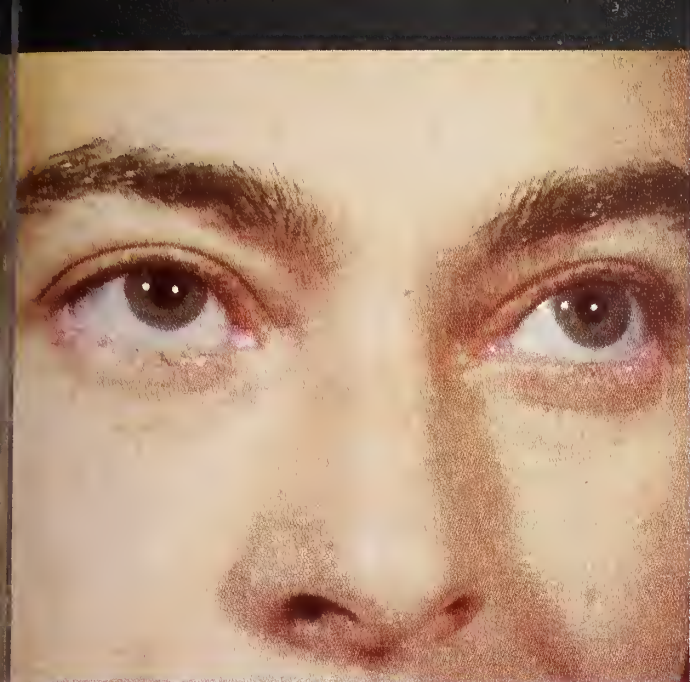
Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten<sup>7</sup> found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

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**AGE 75.** Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



**AGE 68.** Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.

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Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.

spasm extended to about 2 cms. above the umbilicus. There was considerable deep tenderness and rebound. Rectal examination was negative. Catheterization of the bladder showed normal appearing urine.

Immediate laboratory work revealed a white count of 11,500 with 84 per cent polys, 14 per cent lymphs, and 1 per cent monos; hematocrit 49 per cent, hemoglobin 14.5 Gms. The urine was essentially negative. Flat and oblique films of the abdomen were essentially negative.

Because the abdominal signs were so typical of intra-abdominal trauma, the patient was taken to the operating room about one hour after admission. A right rectus incision was made. Upon opening the peritoneum a considerable amount of grayish-tan biliary fluid was noted with a considerable inflammatory reaction evident throughout the small bowel and cecum. Upon further exploration, a Meckel's diverticulum was noted about 55 cms. from the ileocecal valve. This Meckel's diverticulum had a broad base and was hemorrhagic in appearance. There was a small perforation about 4.5 cms. in diameter. There were no other areas of perforation in the small and large bowel. The Meckel's diverticulum was excised and the bowel wound closed transversely with fine line closure.

The specimen was submitted to the pathologist. The pathology report stated that there was no evidence of any ulceration or inflammation throughout the Meckel's diverticulum, however, there was some chronic passive congestion together with a perforated area consistent with traumatic rupture.

Postoperatively the patient was intubated with a Cantor tube and placed on Terramycin intravenously. He did remarkably well and the Cantor tube was removed on the third postoperative day. He was discharged from the hospital on October 1, 1953, the fifteenth postoperative day.

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THE CANCER PROGRAM IN CONNECTICUT

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SUMMARY

A large portion of cancer funds are used for research in the hope that a cause for cancer may be found and a specific treatment employed. This does not mean

that, when accomplished, cancer will disappear from the list of causes of death.

The Connecticut Division of the American Cancer Society has made progress during the past year and these steps are outlined. There is a need for intensification of the educational program in the future. Additional clinical research should be encouraged in the teaching hospitals of Connecticut.

Presidential address delivered at Annual Meeting of American Cancer Society, Connecticut Division, Inc., at Hartford on October 15, 1953



EVERY business organization, because of its very nature, hopes to go on forever, I am sure. Its success depends on how well it meets a recognized need. It may meet that need by producing and marketing a product or by furnishing a service. The American Cancer Society is not a business venture. It is a service organization that does not hope to go on forever but would like to be able to terminate its efforts as quickly as possible. For that reason, unlike a business venture, it spends a large amount of money annually to remove the need for its existence. The money spent for research is not for the improvement of the product but for eliminating the need of it.

Each year brings us reports from the research front that hearten us in our expectation that the cause or causes of cancer may be definitely established, or that a specific treatment may be prepared. Once the cause of cancer is established, however, it does not follow that cancer will immediately cease to be a special problem. The control of the factors responsible may still present a Herculean job. We have seen similar discoveries in the field of infectious disease. Although the bacterial cause of certain diseases was established in the last quarter of the previous century, we are still striving for complete control in these diseases.

Typhoid fever, diphtheria and smallpox are the best examples where most progress has been made in the elimination of preventable diseases. We have been unable to discontinue the prevention programs in these diseases. They continue as a constant threat to health and life. It is not being overly pessimistic to say that the disease, cancer, which has attacked man from virtually his very beginning, will not suddenly be routed by some magic drug or by the discovery of certain cancer producing factors. Every question that science answers merely raises one or more additional questions that must be considered and studied.

Although the Cancer Society is dedicated to a crusade to control cancer, we must be realistic and recognize that control, when it comes, will not be complete in the sense that cancer will disappear from the list of causes of death. We certainly can look forward to moving it from its present second billing to a much lower spot on the list. There will be much to be done even after causes and specific cures are available.

We who are interested in the conquest of cancer must be hopeful realists looking forward to every

new discovery that is made to see how it will add to the over-all attack pattern against this disease. I do not believe we should expect to pick up the paper some day and read that Dr. So and So or some research center has dramatically announced that now our problem is over. News releases that play up such reports are very likely to give the impression that each new discovery may terminate the cancer problem.

When an epochal discovery is actually made, it will mean a complete reorientation of our program. In the meantime, however, we must naturally continually reexamine our program to make sure that we are doing as much as we can with the money donated to cancer to bring about modified control now.

In my report to you last year I raised certain questions which I felt each local branch might well ask itself about its local program. In September of this year the officers of the national society circulated a much more complete list of questions about programs "to stimulate healthy discussion and self criticism." These covered Professional Education, Public Education, Professional Service, Volunteer Service and Organization. I hope that anyone who has not seen this list of provocative questions will avail himself of it. The State office will gladly furnish copies upon request.

In any annual business inventory effort the final question is: "Have we made any money this year?" We can't ask that question. We can ask: "What progress has been made?" First, I believe, our branches are stronger as the result of the last year's effort. This to me was evidenced on two occasions, once when the Executive Committee met with the 18 district presidents for the first time, and secondly when the open meeting of the Board of Trustees was held. On both these occasions the Executive Committee was impressed with the genuine interest of people working in the cancer movement. There was a greater sense of common purpose than I had sensed before.

In the second place the past year saw the Society bring about a reorganization that has affected the State office and all of its subdivisions. The time and thought that each branch and district gave to a study of its by-laws was revealed in the many valuable additions and changes made in the model set of by-laws which were sent out by the State's Standards Committee.

All of this endeavor you know was capped by the national award made to the Connecticut Division by the American Cancer Society. This we accepted with pride tempered by a sense of humility, knowing full well that we still had much to accomplish.

I think we can look with a great deal of satisfaction upon the great activity of the Volunteer Council and regular meetings of branch staff with State office staff. These can only mean a more effective teamwork throughout the whole Society.

One of the more important accomplishments during the year was the work of the Standards Committee. It has long been felt that we needed a job classification and salary plan for similar types of jobs in the Society. This work is about complete and should serve as a valuable guide to the officers at both the state and local level in the years ahead.

I believe one recommendation of the Medical Advisory Committee needs to be lifted out and made conspicuous: that is, the establishment of a fellowship program on a statewide basis with a provision for reviewing all applications in an orderly manner before the awards are made. This program initiated originally in the Hartford Branch is now available throughout the State and should be one more valuable addition to the professional education program.

Each year there has been much discussion about the accomplishments of the detection centers in operation throughout the State. In the past there has been considerable difficulty in evaluating their accomplishments. The past year the Cancer Detection Committee evolved a reporting method which makes it possible to compare the three centers and also to grasp the accomplishment of each.

Since most of you are intimately acquainted with programs of education and service that are being carried on throughout the State, I shall not dwell on them here.

Much of the progress that the Society has made in any year can only be realized when looked at in relationship to our 12 years of existence.

The need for a cancer organization in Connecticut was accepted by leaders of the Connecticut State Medical Society many years ago. They recognized that the cancer problem was two-sided. One side represented the medical phases and the other the social aspects. To handle both required the interest and efforts of the medical profession as a whole as well as that of its constituent members; it also in no small measure called for active participation of laymen. Since physicians recognize that the solu-

tion of the medical problems is highly complex and dependent to a great degree on the relationships that exist between our doctor resources and the people at large, there must have been some medical apprehension that a Cancer Society in its zeal to solve a difficult problem might lose sight of what the medical profession was trying to accomplish both collectively and individually. I believe that the Cancer Society has realized, if not consistently at least continuously, that it could not solve a medical care problem, but that it would complement and supplement wherever it could and not attempt to substitute its activities for those of the doctor. I believe that mutual understanding has continued and been more firmly established.

What about the future? Certainly we must continue much of the program that we have carried out in the past. However, I believe we need to intensify our educational program. We need to invest more time and funds in this field. For one thing we have hardly scratched the surface of the potential of television and I understand that it is here to stay. Education is more difficult than service. It is more difficult to count the number of persons who have had an early discovery of cancer due to an educational program than it is to tabulate those who are discovered in a detection center. The potential, however, is greater because instead of having 12 or 15 doctors looking at a small number of patients, you can have thousands of Connecticut physicians looking at more thousands of properly motivated individuals. Therein lies the potential of early detection in a public education program.

It certainly would seem that the Cancer Society might well promote and stimulate the establishment of some new base lines of behaviour patterns to use as guides for the future.

Since we have withdrawn from supporting pure research, it would be wise for us to foster in our teaching hospitals in the State additional clinical research.

We have actively supported the development of cytological diagnostic services. These have been accepted and have become a part of good medical services. On several occasions doctors have raised the question of making more readily available pathological tissue examination. To date there has been no unanimity of opinion about it. The frequent repetition of the request would seem to indicate a need that should be given continuing attention before its final disposition.



## ANNUAL COUNTY ASSOCIATION MEETINGS

## New Haven, Thursday, March 25

WAVERLY INN, CHESHIRE

Business meeting 4:30 P. M.

Dinner: 7:00 P. M.

*Speaker:* George S. Stevenson, President, Board of Directors, Grace-New Haven Community Hospital*Subject:* "WHAT GOES ON IN THE MODERN HOSPITAL"

## New London, Thursday, April 1

MOHIGAN HOTEL, NEW LONDON

Business meeting 4:30 P. M.

*Speaker:* David Cramer, M.D., Professor of Medicine, Jefferson College, Philadelphia*Subject:* "GANGRENE, ITS DIAGNOSIS AND MANAGEMENT"

## Hartford, Tuesday, April 6

HARTFORD CLUB, HARTFORD

Business meeting: 4:30 P. M., Hunt Memorial Building, Hartford

Social Hour: 6:30 to 7:00 P. M., Hartford Club, Hartford

Dinner: 7:00 P. M.

*Speaker:* Mr. C. Joseph Stetler, Secretary of the A.M.A.'s Committee on Legislation

## Middlesex, Thursday, April 8

COMMODORE MACDONOUGH INN, MIDDLETOWN

Business meeting 4:30 P. M.

Dinner: 6:30 P. M.

Speaker and subject to be announced

## Fairfield, Tuesday, April 13

STRATFIELD HOTEL, BRIDGEPORT

Business meeting 4:30 P. M.

Dinner: 7:30 P. M.

*Speaker:* Colonel Leon W. Gray*Subject:* "ADVENT OF JET PROPULSION"

## Litchfield, Thursday, April 15

DEER ISLAND GATE, MORRIS

Social Hour 6:30 P. M.

Dinner: 7:00 P. M.

*Speaker:* James S. Hart, M.D., Director of Bureau of Preventable Diseases of the Connecticut State Department of Health*Subject:* "POLIO VACCINE FIELD TRIAL"

## Windham, Thursday, April 15

Place and speaker to be announced

## Tolland, Tuesday, April 20

Place and speaker to be announced

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### Hartford Beckons Once More

Hartford again will welcome the Connecticut State Medical Society when it convenes in that city for its 162nd annual meeting this month. In so doing it pays tribute to the Hartford Hospital in its centennial observance and it is most fitting that the foster parent, 62 years its senior, should take cognizance of the leadership which the Hartford Hospital has assumed in many fields, notably in medical education.

A colossal giant of brick, stone, steel and glass, this institution has risen to great heights during the years as a haven for the sick, providing one of the best rotating internships in the East; it has become a leader in medical and surgical care in the State, and is a community supported hospital with a research program of no mean dimensions.

Many of the most prominent members of the former Connecticut Medical Society, now the Connecticut State Medical Society, were the founding fathers, the guiding spirits as it were in the growth and development of Hartford Hospital.

"True glory dwells where glorious deeds are done,  
 Where great men rise whose names athwart the  
 dusk

Of misty centuries gleam like the sun!"\*

This is not the oldest institution of its kind in Connecticut, the New Haven Hospital holding that distinguished honor. It is not as venerable as the Hartford Retreat (now the Institute of Living), nor

the former American Asylum for the Deaf and Dumb, more pleasantly named School for the Deaf. To find a suitable meeting place for the State Society, devious routes were pursued such as Gilman's Saloon, the old State House, the United States Hotel, the County Court House, various and sundry halls. It must have been in a salutary atmosphere that the State Society held its annual meeting on a few occasions within the walls of the new hospital in Hartford.

Instead of dissertations on "The Prophylaxis of Phthisis Pulmonalis," "The Water Treatment of Scarlatina Especially by the Wet Sheet Pack," and "The Deleterious Effects of Ardent Spirits," we find on the 1954 scientific program a discussion of the latest development in the clinical application of radioisotopes, the use of the artificial kidney, and the surgical treatment of coronary insufficiency. Dr. Nolan and his committee have prepared an outstanding program from the store of modern medicine to be presented by leaders in the profession. The 162nd annual meeting in Hartford offers a valuable two day refresher course in postgraduate medicine.

### Participating in Success

"By every standard of measurement which may be applied to an enterprise such as ours, 1953 has been our most successful year. We have increased the benefits to our subscribers and the stability of the Corporation and have developed an organization to better meet the needs of Connecticut in the years ahead."

\*Foulke's "The City's Crown"



That is the opening paragraph of the Annual Report of the Executive Director to the Board of Directors and Professional Policy Committee of Connecticut Medical Service after five years of operation. Each word of it will be appreciated by the people of this State. Connecticut Medical Service belongs to the people and we in medicine are entrusted with the responsibilities of stewardship and achievement.

Substantial as the Managing Director's statements are, there is more to be said about CMS progress in its brief life. It was, for much of that time, the most rapidly expanding plan in the country and may well have that position again after slowing up in recent months, due to many outside influences. In services rendered Connecticut Medical Service has an extraordinary record. 101,534 subscribers' claims were paid in 1953, 500 more per week than in 1952, an increase of over 37 per cent. 700,000 people were covered at the years end, a gain of 109,000 in 1953, it is one-third of the population of the State. Physicians were paid \$5,338,763 for their services which added to the payments in the four previous years made the striking total of \$14,363,123.

Impressive as these items are, there is another element inherent in this operation which cannot be so easily stated as figures on case load and dollars paid. It is the human factor, the intrinsic willingness of men of medicine to be of service to their fellow men. An often quoted definition of a profession applies aptly here. "A profession," Judge Pound said, "is an organized calling in which men pursue a learned art and are united in the pursuit of it as a public service—no less a public service because they make a livelihood thereby." Brilliant as the financial and managerial success of CMS has been, it could not be what it is if it did not have the cooperation of the Participating Physicians. There are more than 2,100 of them. 153 were added last year, they constitute 85 per cent of the practicing physicians in the State and in 1953 these understanding men and women not only carried out the provisions of the participating agreement but they voluntarily rendered services to 11 per cent more cases on a service basis when additional charges could have been made. Without them there would not be Connecticut Medical Service at all but only a medical indemnity scheme with limited purpose. Public confidence and personal satisfaction come from this participation.

## On Medical Writing

A few years ago an outspoken medical educator suggested that it would be a good thing if a moratorium was declared on medical writing to give an opportunity to separate the wheat from the chaff and to digest that which was nutritive. It is probably better that this cynical advice could not be followed but many medical articles might be left unwritten without much harm. However, if they are going to be written it is worth doing them well.

Anyone contemplating medical authorship should have "Rx for Medical Writing," on his desk and it would be better if he read it through before he started. "Rx" is a little book by Edwin P. Jordan and Willard C. Shepard. Dr. Jordan was formerly assistant editor of the *Journal of the American Medical Association* and is now the producer of a daily health column syndicated by three hundred newspapers, he likes to write and knows how to do it. The theme on the flyleaf of this helpful volume is a quotation from Alexander Pope—

"True ease in writing comes from art, not chance  
As those move easiest who have learn'd to dance."

This is not a review of this valuable book, it is rather comment hoped to encourage medical writers to consult it, especially those with limited experience. Two quotes will give a hint.

On subjects, Dr. Jordan says: "The medical literature is already overburdened with papers which are merely rehashes of information previously published. Hence it is important that the subject should be one which stands a reasonable chance of making a contribution to the advance of knowledge."

After it has been decided that the subject is worthwhile and not just an opportunity to burst into print, then comes the craftsmanship of setting it down on paper so as to interest and inform the reader. On that Jordan presents the basic truth of all writing—"The foundation of language, spoken or written, is the individual word and its positioning in the sentence. The rules of grammar are supposed to cover all this and make it easy, but many of us have forgotten what grammar we may have known; too, grammar alone does not solve all problems of writing. Reading and practice improve the ability to select words and put them together, but choosing the right word and using it in the right place is never easy."

Medical writing is a fascinating and productive business, it is also a difficult and elusive art. With some it is a disease. Its essential purpose is to inform the reader and have him understand what is being said.

### Solving Connecticut's Blood Needs

The Connecticut Regional Blood Program will shortly celebrate its 4th anniversary in the service of the citizens of Connecticut through the 44 hospitals served by the Program. Since June of 1950, 352,978 pints of blood have been collected, a figure of which the Program is justifiably proud, and one which more than proves the interest of Mr. and Mrs. Average Citizen.

It is well recognized by all hospital pathologists that the needs for blood vary widely from day to day, the needs some days being 2,000 per cent of the needs for other days. It is further recognized that blood outdates in 21 days. With these thoughts in mind, the Central Bank has tried to maintain a two weeks' supply of blood based on bed occupancy in each of the member hospital banks, hoping by this means to reduce emergency calls by the hospitals. It was agreed that the Center would fill the hospital bank to a two weeks' level, by type, through weekly deliveries, and that failure to do so would indicate to the member hospital that the Center was out of blood. This signal to the member hospital would enable it to take steps to husband its own resources and to contact neighboring hospitals and the local Red Cross chapter for help.

The basis for the determination of the blood bank level in member hospitals is the fourteen day average usage per occupied bed, not in excess of twelve pints per occupied bed per annum, types being allocated on the ratio of: O—45 percent, A—40 per cent, B—10 per cent, AB—5 per cent, 15 per cent of which are negative. Two problems are partially solved by this method. It insures to all hospitals their fair share of all blood collected; and, by increasing the amount of blood on the shelves of the hospital blood banks, reduces the number of emergency calls. It did not, however, solve the problem of the fair distribution of "O," or universal type blood.

It is recognized by the Center that requests for A, B, or AB blood may be issued to the limit of collections, as these bloods are only usable for specific patients. In the very rare types (B negative and AB negative) the Center in general only fills orders for

specific recipients already hospitalized. As "O" type blood can be used universally, its fair distribution is guided by the following considerations. The two weeks' normal usage of "O" blood of each hospital is known, and except in periods of plenty cannot be exceeded without endangering the supply of "O" blood to other member hospitals. In addition the supply must be geared to collections. If total collections fail, total "O" type blood available to hospitals is reduced. There is, therefore, apportioned to each hospital on a percentage basis the "O" type blood received by the Center, all hospitals sharing the overall supply on an equal basis.

The system as outlined has on the whole worked well. The weakest link lies in maintaining the continued interest of donors to the Program, who through their local Red Cross chapter are the instruments whereby the quota set up by the Center may be met or exceeded. It is in this phase of the Program that the medical profession can be of great help. The physician can stress to his patients the ease and simplicity of donation. He can stress the perishable nature of blood with the need for continuous replenishment of the blood bank. Recipients of blood and their families know well what availability of blood has meant to them, and they are in a receptive mood. It is, however, not often explained that this availability is made possible through the services of the Red Cross and that there is no charge for the blood itself. It is in this field of good public relations and publicity that the medical profession can help itself and the people of this State in maintaining and strengthening the Blood Program.

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### Hartford Hospital Appoints Assistant Director

Following the selection and establishment in the Hartford Hospital of the new director, Dr. T. Stewart Hamilton, a new assistant director has been selected and began his duties March 1. The new appointee is Dr. Ernest C. Shortliffe of Edmonton, Alberta. He is a native of Edmonton and received his B.A. and medical degrees from the University of Alberta. He has studied in the Department of Hospital Administration, School of Hygiene of the University of Toronto, and will receive a diploma in hospital administration on completion of his thesis. Dr. Shortliffe has practised medicine in Alberta and also served in the Royal Canadian Air Force.



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## Progress in Clinical Medicine

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### SURGERY IN ACQUIRED HEART DISEASE

R. LEONARD KEMLER, M.D., *Hartford*

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IN 1922 Elliott Cutler was quoted as saying that "the heart is the last frontier of surgery." Since that time, and most particularly in the last decade, that frontier has been pushed back, so that now the surgeon has at his disposal many techniques that permit the correction of congenital heart defects and the repair of the damage caused by acquired heart lesions. It is the purpose of this paper to review the criteria necessary to establish the existence of acquired heart disease that is amenable to surgical treatment, and to indicate the methods of surgical correction.

The types of acquired intrinsic heart disease presently amenable to surgical therapy may be classified as traumatic, pericardial, valvular, neoplastic, thrombotic, and arteriosclerotic.

#### TRAUMATIC DISEASE

The concept that wounds involving the heart are invariably fatal held sway for many centuries and was essentially true. The first successful suture of the heart on record was that of the German surgeon Rehn.<sup>1</sup> In both World War I and World War II considerable experience was gained in the treatment of these injuries and substantial numbers of patients with penetrating heart wounds and even intracavitary foreign bodies were saved from death. Traumatic disease of the heart includes contusion and concussion which are caused by blunt trauma to the chest wall or by blast injury. Contusion is characterized pathologically by diffuse petechial hemorrhage or gross subepicardial hematoma. Severe hemorrhage into the muscle substance may be associated with mural thrombi and even coronary thrombosis.

Clinically the patient is pale, anxious and restless, with complaints of substernal pain. Low systolic and low pulse pressures are the rule. Pericardial effusion

#### SUMMARY

An attempt has been made to show the progress made in the surgical management of acquired heart disease in the last ten years. There are definitive procedures for the treatment of traumatic and pericardial lesions. Mitral commissurotomy is an established operation for the treatment of mitral stenosis. Aortic commissurotomy is rapidly assuming a place in the treatment of aortic stenosis. Experimental procedures have been indicated that may prove to be the answer to the difficult problems associated with mitral insufficiency and arteriosclerotic heart disease. Time alone can evaluate these procedures.

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may occur and paracentesis may be indicated. An electrocardiogram should be taken and this may show abnormalities suggestive of myocardial infarct.

The treatment is nonsurgical and follows closely the general lines for coronary thrombosis. The prognosis is very serious because of the ever present danger of cardiac standstill or ventricular rupture.<sup>2</sup>

Penetrating wounds of the heart, when large, are usually promptly fatal because of hemorrhage. But when caused by a narrow-bladed instrument, such as a knife or ice pick, a stab wound may lead to relatively slow bleeding from the heart. This bleeding may be readily tamponaded by accumulated blood and serum within the pericardium if a clot obstructs the small pericardial rent. While this increasing tamponade may actually stop further cardiac bleeding, it usually does so only at the price of severe restriction of cardiac diastole. The latter, if severe, may itself cause death.

The signs of tamponade may develop insidiously some minutes or hours after the injury. In its earlier forms it is characterized by elevated venous pressure

(distended superficial veins), increased precordial dullness, muffled or distant heart sounds, and a low systolic blood pressure with a relatively high diastolic pressure. There also may be "paradoxical pulse" (diminution in force, or disappearance of the pulse on deep inspiration), pallor, anxiety, sweating, etc. Fluoroscopically one sees a greatly enlarged heart shadow with little or no pulsations at the borders.

The treatment of suspected penetrating injuries of the heart is directed towards two objectives, (1) to immediately relieve the greatly increased intrapericardial pressure, and (2) to suture the bleeding chamber. In some clinics immediate surgical exploration is undertaken, and associated shock or poor condition of the patient is not permitted to delay this definitive surgery. Simultaneous fluid and blood administration during the period of definitive attack is considered sufficient concomitant supportive therapy.

Other workers such as Elkin and Campbell,<sup>3</sup> and Blalock and Ravitch,<sup>4</sup> have advised that penetrating wounds of the heart be treated more conservatively. They recommend diagnostic and simultaneous therapeutic pericardial aspiration while supportive measures are being carried out. This can be done using the substernal paraxiphoid route of aspiration, which is the safest from the standpoint of avoiding injury to the heart muscle or major coronary arteries, or an alternate parasternal puncture in the left 5th or 6th interspace can be used. If symptoms are relieved after aspiration and do not recur, no operation is indicated. If symptoms recur, however, then surgical exploration of the pericardium with attempted suture of the heart muscle is indicated.

The prognosis depends greatly upon the severity of the injury. Bigger collected 144 cases by various writers with an overall recovery of approximately 50 per cent. The causes of death are (1) uncontrollable hemorrhage, (2) tamponade, (3) disruption of a cardiac valve, (4) major coronary occlusion, (5) disturbance of cardiac conduction tracts and (6) infection.<sup>2</sup>

#### PERICARDIAL DISEASE

Pericardial surgery may be divided into the treatment of (1) serous or serosanguinous effusions, (2) purulent pericardial effusions, and (3) constrictive pericarditis.

(1) Serous or serosanguinous effusions may be caused by a variety of etiologic factors. Among these rheumatic fever and tuberculosis are of principal

concern. The development of an acute pericarditis, since it usually complicates a serious systemic illness, may be overshadowed by the evidences of the latter, and may even be entirely overlooked. Precordial or substernal pain that may be pleuritic or may radiate to the shoulder is a common finding at some stage of the disease. Other symptoms related to pressure effects have already been discussed in the above paragraphs. The most characteristic sign is a pericardial friction rub, usually heard early in the course of the disease. With the development of fluid, however, this sign tends to become lost. Precordial dullness then becomes increased, and the heart sounds become distant. Radiographically the heart shadow becomes enlarged, and the pulsations become diminished or absent. In the oblique position a characteristic posterior bulge of the cardiac silhouette can be seen.

Treatment is directed in two channels, one towards the basic disease and the other towards relieving the effusion. Multiple pericardicentesis are used to relieve pain and prevent tamponade. Because of the impossibility of completely evacuating the pericardial sac by this means, Donaldson<sup>5</sup> has recommended that dependent surgical drainage be employed. It is felt by most workers, however, that simple pericardicentesis should be employed first and, if this fails, then surgical drainage should be used. This drainage can be done under local anesthesia, resecting either the xiphoid process, or the sixth and seventh left costal cartilages. The pericardial sac is then entered and drained with a Penrose drain.

(2) Purulent pericardial effusions are now usually treated by vigorous systemic antibiotic therapy, and by needle aspirations when necessary. Because, in most cases, deposition of fibrin upon the lining of the pericardial cavity will lead to organization and to the eventual development of constrictive phenomena, early surgical drainage as outlined above is also indicated.

(3) Constrictive pericarditis is a disease state in which previous inflammation has produced an investing fibrous or calcific pericardial shell. It is nearly always the end result of an acute pericarditis, though the acute stage is frequently overlooked. At one time it was considered to be usually rheumatic in origin, but now it is believed that most cases are of tuberculous or pyogenic etiology. It is deleterious to the circulation mainly by virtue of its constrictive effect upon the ventricles, the thin walled vena cavae, and



the auricles. It is generally believed that the heavy leathery or calcific pericardium contracts because of fibrosis, and limits the extent of diastole of the ventricles. Since they cannot fill to a normal capacity, they cannot eject the normal amount of blood per systole. This is compensated for by an increase in venous pressure, an increase in heart rate, and by progressive limitation of physical activities. As these possibilities of compensation become exhausted, both forward and backward failure follow.

The symptoms are those of dyspnea, ascites, peripheral edema, and occasionally jaundice.

The signs of constrictive pericarditis are low systolic blood pressure with a relatively high diastolic pressure, a weak pulse which may become paradoxical, distended superficial veins, muffled heart sounds, ascites and peripheral edema, and a small heart on fluoroscopy with considerable diminution in the extent and degree of cardiac pulsations and movement. Direct measurement of peripheral venous pressure may show hypertension as high as 400 mm. of water. Cardiac catheterization shows high right atrial and ventricular pressures with a low cardiac output. The electrocardiogram usually shows low voltage in all leads with inverted T waves. Occasionally calcification of the pericardium may be visualized radiographically.

The cases of constrictive pericarditis have a poor prognosis under conservative management since the disability is progressive. Digitalization, mercurial diuretics, and a low salt diet should be employed. However, after a brief medical preparation, surgical therapy should be undertaken.

Delorme<sup>6</sup> first advised and Rehn<sup>7</sup> first performed a partial pericardectomy for constrictive pericarditis. Since then Churchill,<sup>8</sup> Beck,<sup>9</sup> and Heuer and Stewart<sup>10</sup> have made notable contributions to the surgery of this condition. These men have used an extrapleural type of operation in which a semicircular incision is made over the precordium, the convexity being directed to the right. The costal cartilages to the left of the sternum are removed and the pericardium is resected. A cleavage plane can usually be developed between the fibrin peel and the intact epicardium. Through this incision it is possible to completely remove the pericardium and peel over the right ventricle, the superior vena cava, and part of the left ventricle. Other workers have felt that mobilization and permanent release of the left ventricle are the most important parts of the procedure, and they have chosen a left transpleural approach through a posterolateral thoracotomy incision.

Recently Holman and Willett,<sup>11</sup> and Holman<sup>12</sup> have advised a sternum-splitting approach for pericardectomy in constrictive pericarditis. Thus, we can see that the operator has the choice of three exposures. All have some merit, and none completely satisfies all requirements. It must be left to the individual surgeon to choose the approach best suited to any given case.

Dramatic improvement may follow operation with rapid reduction in venous pressure, relief of ascites, and steady diuresis and weight loss. It must be remembered, however that in those cases in which the myocardium has been badly damaged and scarred, the improvement may be a slow and gradual one, and it may be several months before the results of the operation become manifest.

#### VALVULAR DISEASE

The acquired forms of cardiac valvular deformity which are sufficiently common to justify surgical consideration are (1) tricuspid stenosis (rare), (2) mitral stenosis, (3) mitral regurgitation, (4) aortic stenosis and (5) aortic regurgitation. They are usually the result of rheumatic fever—a worldwide endemic disease, particularly common in temperate climates.

Rheumatic fever is a pancarditis, attacking both the myocardium and the valves. The myocardium usually heals by scarring. The valves become the seat of vegetations, which appear along the lines of closure. These vegetations and a zone of inflamed adjacent valvular tissue become invaded by fibrous tissue. The commissures also become “frozen” by this fibrous tissue infiltration. This produces stenosis with a mechanical barrier to the flow of blood. Insufficiency frequently accompanies the stenosis. It is a consequence of shrinkage or rolling of the leaflets as the scar tissue contracts, and also of shortening of the chordae tendinae which frequently become involved in the process. Occasionally the myocardium may be diseased at the valve annulus, producing dilatation of the annulus with resultant insufficiency without stenosis.

#### (1) Tricuspid Stenosis.

Clinical rheumatic tricuspid stenosis is a rare disease, usually presenting as a part of a complex valvular syndrome with mitral or aortic lesions or both. Its anatomic similarity to mitral stenosis makes it suitable for surgical correction, either by simple digital dilatation or by incisional enlargement through the right auricular appendage. Harken has already performed this operation. Since tricuspid

stenosis is quite rare, and since its surgical correction is similar in most respects to that of mitral stenosis, further discussion of this lesion will be omitted.

## (2) Mitral Stenosis.

Mitral stenosis is by far the most common valvular lesion caused by rheumatic disease. The ultimate pathologic stage of the rheumatic mitral valve is a rigid slit in a fibrotic or calcific plaque. The obstructive effects of mitral stenosis inevitably follow the logically expected pattern. The pressure in the left auricle rises, and it becomes dilated and hypertrophied. This high vascular pressure is transmitted through the pulmonary veins to the capillaries, arterioles, and to the pulmonary artery itself. Chronic pulmonary hypertension produces thickening of the pulmonary vessels and eventual parenchymal fibrosis. The right ventricle undergoes progressive dilatation and hypertrophy, resulting eventually in failure. With this, all the signs of systemic congestive failure become evident: distended neck veins, enlargement of the liver, ascites and pleural effusion, and dependent edema.

The symptoms of mitral stenosis are essentially dyspnea on exertion, hemoptysis, and cough. The pathognomonic signs are (a) a rumbling diastolic or presystolic murmur heard best at the apex, and (b) radiographic evidence of a large left auricular shadow, usually demonstrated in the right anterior oblique view with barium swallow or in the left lateral projection with barium swallow. Cardiac catheterization may demonstrate an elevation of the pulmonary artery pressure and right ventricular pressure. The electrocardiogram usually shows right axis deviation.

The idea of opening the stenotic mitral valve using the finger or an instrument is not a new one. Allen and Graham attempted it in 1922.<sup>13</sup> Cutler, Levine and Beck<sup>14</sup> reported a successful case in 1924, and Souttar reported a successful case of digital dilatation in 1925. It remained, however, for Bailey<sup>16</sup> of Philadelphia and Harken<sup>17</sup> of Boston to bring mitral commissurotomy eventually into the circle of acceptable surgical procedures.

It is the aim of surgery to open the mitral valve along its commissures using the index finger to split the commissures, or using special knives when necessary. The problem of the selection of cases for commissurotomy always arises. Two schools of thought have developed on this subject. Brock<sup>18</sup> has stated: "The indication for commissurotomy in

mitral disease is the existence of mitral stenosis." Bailey<sup>19</sup> has shown that the pathologic process and the actual degree of obstruction of the mitral valve in mitral stenosis are much more advanced than the clinical symptoms suggest. He points out that it is wrong to wait until the great compensatory powers of the circulation are exhausted before considering surgical intervention. Obviously one cannot justify such a broad indication for surgery unless one can demonstrate that the risk of the operation is smaller than the risk of the disease. In the cases submitted to surgery early, the operative mortality is of the order of 1 to 2 per cent. If one limits his operative experience to advanced and serious cases, the mortality rises to 20-25 per cent. Thus early operation combines a minimal risk with a maximal gain, for the myocardium will be relatively undamaged at that stage of the disease.

The other school believes that many patients with mitral stenosis may live relatively normal lives without operative intervention, and they feel that operation should be reserved for the more advanced cases. Even in the latter group, however, the trend is towards earlier operative interference.

Contraindications for mitral commissurotomy are relative and are in a state of flux. One must always weigh the risk of conservative management in each case, and sometimes a serious calculated risk must be accepted.

The limitations in respect to age are gradually being extended both upwards and downwards. Beyond the age of sixty, however, the risk of surgery becomes quite high.

The presence of overt rheumatic activity or subacute bacterial endocarditis are definite contraindications to surgery. After an adequate medical regimen, however, these patients should be reconsidered. A slightly increased sedimentation rate, however, is not a contraindication to surgery.

Extreme cardiac enlargement implies severe myocardial damage or destruction and is essentially irreversible. It is doubtful if these patients could survive the operation, and if they would survive, clinical improvement would usually be slight or nonexistent. This is a definite contraindication to operation, as is persistent, intractable heart failure.

Neither auricular fibrillation nor a history of previous arterial embolization is considered a contraindication to surgery, though each of these conditions increases the operative risk significantly.



Briefly the technic of the operation consists of entering the chest through a left posterolateral approach. The pericardium is opened, and a purse string suture is placed at the base of the left auricular appendage. The appendage is opened, and the surgeon's index finger is quickly inserted into the auricle, while an assistant tightens the purse string suture about the surgeon's finger. The surgeon then splits the commissures with his index finger, or, if this is impossible, withdraws his finger part way and inserts a special valvulotome knife to complete the valvular incision. When a satisfactory opening has been made, the finger is withdrawn and the purse string is tied. The chest is then closed in the usual fashion. Blood loss during this procedure is usually quite small.

The overall mortality for this procedure in all types of cases ranges between 10 and 15 per cent (Bland).<sup>21</sup> Bailey<sup>19</sup> has reported 83.2 per cent definite improvement in 178 patients that he has followed from one to four years.

The question inevitably arises as to the ultimate fate of the operated patients. It is naturally too early to make any predictions, but thus far less than ten per cent of the patients that have been successfully operated on have shown any return of stenosis, and in many of these cases the return of symptoms has been extremely mild.

### (3) Mitral Insufficiency.

As has been noted above, there are two types of mitral insufficiency, one associated with a mitral stenosis and a hard open valve orifice, and one associated with a dilated atrioventricular ring (annulus) and a large flexible valve. It is easier to make the diagnosis of the latter than the former.

Clinically mitral insufficiency is characterized by great left ventricular enlargement with a loud systolic apical murmur. Great obvious evidences of cardiac disability with dyspnea on exertion, weakness, congestive heart failure, and auricular fibrillation complete the picture. Mitral insufficiency associated with stenosis may be quite difficult to diagnose preoperatively.

At the present time surgery for this lesion is in the experimental stage. Harken has attempted to block the regurgitation by suturing a plastic bottle just below the valve orifice. The bottle serves as a ball valve to prevent regurgitation. Bailey<sup>19</sup> has attempted to close the commissures by using a transventricular approach, and suturing the mitral valve at its commissures using living pericardium as a suture

material. Neither method has achieved consistently good results, and consequently neither method has achieved wide acceptance.

### (4) Aortic stenosis.

The changes leading to aortic stenosis are entirely similar to those observed in the mitral valve. Fusion may occur along all the commissures leaving only a small central opening. The left ventricle becomes hypertrophied, the blood pressure and pulse pressure become low, and the cardiac output becomes fixed. Uncommon exertion thus can cause dizziness, an anginal type of pain and frequently sudden death. The electrocardiogram shows left ventricular strain.

Aortic stenosis has been attacked surgically using special instruments and utilizing a transventricular approach. The valve is split at its commissures in a fashion similar to that used for mitral stenosis. Though this procedure is relatively new, its results are extremely encouraging.<sup>22</sup>

### (5) Aortic Regurgitation.

This lesion has not been successfully attacked in human beings to date. Animal experimentation is being carried out by application of a plastic valve within the aortic lumen (Hufnagel),<sup>23</sup> and by using pericardial tissue across the aorta to provide living valvular tissue where there is a dearth.

## NEOPLASTIC AND THROMBOTIC DISEASE

These conditions are considered together because of similar technical problems. The vast majority of tumors of the heart are metastatic and are obviously unsuitable for resection. Primary tumors of the heart are rare and are extremely difficult to diagnose except at autopsy. One tumor, a benign fibromyxoma, may arise on the interatrial septum and cause all the symptoms of mitral stenosis. This tumor can be freed by intra-atrial finger dissection using the usual commissurotomy technique. It is removed from the auricle by making a second incision in the left superior pulmonary vein, so that a finger may be inserted through it into the auricle. Thus one can manipulate the free mass into the already open auricular appendage. The same method can be used to remove intracardiac thrombi that do not flush out by allowing the auricle to bleed for one or two beats.

## ARTERIOSCLEROTIC DISEASE OF THE HEART

Attempts to reconstitute an adequate arterial supply to a myocardium that has undergone ischemic change or actual infarction have gone along three channels. The first attempts have been directed

towards the development of extracoronary sources of blood flow by utilizing tissue grafts of pericardium, propericardial fat, omentum, and of lung to the myocardial surface. Most of these procedures have met with little success.

Other attempts have been aimed at stimulating intercoronary communications by mechanical or chemical irritations of the epicardium and subjacent myocardium. Powdered asbestos has been one agent used for that purpose. Thompson and Plachta<sup>24</sup> have reported favorable results by inserting magnesium silicate powder (U.S.P. talc) within the pericardial sac. This has produced an acute inflammatory reaction which terminated in a chronic, adhesive granulomatous pericarditis with extracardiac and intracardiac vascular anastomoses, known to persist for ten years. No cases of constrictive pericarditis were reported.

The most recent attempts were directed towards establishing vascular anastomoses between systemic vessels and the myocardium or between the aorta and the coronary sinus and its tributaries. Vineberg<sup>25</sup> has successfully transplanted the internal mammary artery directly into the myocardium of the left ventricle. This has formed an anastomosis, furnishing a third artery to the left ventricle beyond the points of coronary occlusion. It has been successful both in dogs and in man. Beck<sup>26</sup> has made an anastomosis between the descending aorta and the coronary sinus by means of a free vein graft or an arterial graft. After the function of the anastomosis has been well established (by the passage of three or more weeks) the outlet of the coronary sinus is ligated. The arterial blood flow goes through the graft to the coronary sinus and then backward through all the ramifications of the coronary venous system. Venous return is through innumerable small channels opening into all four cardiac chambers. There have been successful results in both animals and in man. Though the results of both of these operations have been reported as favorable, one must of necessity await long-term evaluation before forming a definite conclusion.

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## THE PRESIDENT'S PAGE

WITH this page your president terminates his messages to the doctors of Connecticut and soon will surrender the duties and obligations of his office to his capable successor. This will end a year that has been a most happy and rewarding experience.

To have been the head of an organization that dates back to 1792 has been an honor and an experience deeply appreciated and forever cherished.

I take great pride in a Society that has achieved so much, and in the friendships I have had with the men I admire and like who represent you. These men give freely and unselfishly of their time and thoughts in order to help solve the problems of this association and of Connecticut medicine.

I appreciate the help of the staff of our State office and I am sure that the contributions our executive secretary has made in his years of service are greater than anyone can realize until they have worked closely with him.

Our CONNECTICUT STATE MEDICAL JOURNAL is outstanding and I admire the competency and devotion of those who have given so much of themselves to make it such a success.

I am proud of our surgical-medical care plan, Connecticut Medical Service, which is growing so rapidly and now serves so many people in this State.

I am pleased with the fine development and increase of the Emergency Medical Call Plans which supply a real need in so many communities.

I believe that the quality of medical care in Connecticut is excellent and will continue to improve.

With the fine leadership and good sense that exists in this Society I know we will go forward to greater and better things in the years to come.

George H. Gildersleeve, M.D.

# THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH  
*Director of Public Relations*

JOSEPHINE P. LINDQUIST  
*Administrative Assistant*

160 ST. RONAN STREET, NEW HAVEN

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## CALL

### ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1954 Annual Meeting of the House of Delegates will be held in the auditorium of the Bulkeley High School, 470 Maple Avenue, Hartford, commencing at 10:00 o'clock in the morning on Tuesday, April 27.

Following luncheon, the House will reconvene for the completion of business.

George H. Gildersleeve, President  
Creighton Barker, Secretary

### Council Meeting

The monthly meeting of the Council was held at the offices of the Society on March 11, 1954. The meeting was called to order by the Chairman at 3:45 P. M. There were present in addition to the Chairman, Dr. Danaher, Drs. Gildersleeve, Couch, Barker, Weld, Whalen, Fincke, Gallivan, Walker, Tracy, Gettings, Labensky, Ottenheimer. Speaker of the House Dr. Gibson, Vice-Speaker Dr. Feeney, Alternate Councilors, Drs. Gens, Ursone, Otis, Archambault. Absent: Drs. Marvin, Murdock, Flaherty and Alternate Councilors Drs. Ogden, Buckley, Gilman. Also present by invitation were Dr. William H. McMahon, chairman, Committee on Professional Relations and Dr. D. Olan Meeker, chairman, Committee on National Legislation.

#### POLIO VACCINE FIELD TRIAL

It was voted to approve the proposal for the field trial of poliomyelitis vaccine during the summer as proposed by the National Foundation for Infantile Paralysis under the direction of the State Department of Health, with the proviso that it be made quite clear to the public that it is an experimental field trial. (AMB 3/11/54 "A")

#### CMS CLAIMS FOR SERVICES OF RESIDENTS

The Council, at its meeting on January 14, 1954,

requested the Chairman to endeavor to find out if the Connecticut Medical Service claim blank could be amended to permit a physician or surgeon to file a claim stating that he was responsible for the care of an insured person although the services were actually rendered by a member of a resident house staff. Dr. Danaher reported that this inquiry had been directed to the Legal Counsel for Connecticut Medical Service and a reply had been received from him as follows: (AMB 3/11/54 "B")

"In my opinion it would be inimical to the best interests of Connecticut Medical Service to pay such claims. It also seems to me that it would be contrary to the public interest, and since we are a nonprofit tax free institution, we should be especially concerned with the public interest. The proposal would open the door to bad practices, some of which have been recently exposed."

The secretary was directed to have this information published in the CONNECTICUT STATE MEDICAL JOURNAL.

#### PROFESSIONAL POLICY COMMITTEE

Dr. Tracy, chairman of the subcommittee appointed to consider the resolution from the Hartford County Medical Association concerning membership of the Professional Policy Committee of Connecti-



cut Medical Service, reported that the committee wished to propose to the Council that the Board of Directors of Connecticut Medical Service be asked to amend the By-Laws of Connecticut Medical Service to provide for increase in membership of the Professional Policy Committee from the present nine to twelve. This committee to consist of four physicians selected from the Board of Directors of Connecticut Medical Service by the Board and eight additional physician members to be nominated by the Council of the State Medical Society. The purpose of this increase in membership is to provide opportunity for additional members from the field of general medicine. (AMB 2/11/54 "D")

#### MEDICAL SCHOOL SCHOLARSHIPS

It was voted to recommend to the House of Delegates that five medical school scholarships of \$500 each be awarded during the school year 1954-1955 to Connecticut students in approved medical schools in the United States or Canada in the same manner as the scholarships were awarded for the school year 1953-1954. The nursing school scholarships, as awarded in 1953, are to be discontinued.

#### ASSOCIATE MEMBER NOMINATION

It was voted that the name of Mr. Hiram Sibley be proposed to the House of Delegates on April 27 for election as an associate member of the Society as provided in Article V, Section 4, paragraph 1 of the By-Laws. (AMB 3/11/54 "C")

#### AMA AND OSTEOPATHY

The following action adopted by the House of Delegates of the American Medical Association at its Annual Meeting in New York, June 1953, in regard to the status of osteopathy was discussed.

"Because of the length of the Committee report and the controversial nature of the subject, the Board of Trustees of the AMA feels that the House of Delegates should have adequate time for its study and that the State Associations should have opportunity to express their opinions.

"Therefore, it is recommended that the Committee for the Study of Relations between Osteopathy and Medicine be continued, but that action on the report be deferred until the June 1954 session in San Francisco. It is suggested that at that time the House of Delegates of the AMA be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include the improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

It was agreed that delegates from this Society to the American Medical Association be not 'instructed' on this matter for their action at the House of Delegates meeting in San Francisco in June 1954 and that the Speaker of the House of Delegates of this Society be directed to bring the subject to the attention of the members of the House at its meeting on April 27 and invite any members of the House who wish to express their opinion to confer with any one of the three delegates to the American Medical Association. (AMB 3/11/54 "D")

#### NATIONAL LEGISLATION REPORT

D. Olan Meeker, chairman of the Committee on National Legislation, present by invitation, presented a verbal report of the activities of that committee. He outlined the necessity for prompt action in regard to many national legislative matters through contact with Connecticut representatives in the Congress and the practical impossibility of obtaining opinion from all of the members of the Society or even from the Council. He asked the Council to make suggestions how the committee might operate more satisfactorily and efficiently and no suggestions were made. It was finally voted that the Council give its approval to the program and activities of the Committee on National Legislation as outlined by Dr. Meeker and thanked him for presenting the report.

#### BY-LAW REVISION

Dr. Danaher reported for the subcommittee that had been appointed to make nominations for a committee to review certain sections of the By-Laws and asked that before he proceeded to make nominations for this committee that its purpose and objectives be clearly defined. It was agreed that the committee would be appointed for the purpose of suggesting amendments to the By-Laws and Charter of the Society to clarify membership on the Council particularly relating to alternate councilors, Speaker and Vice-Speaker of the House.

## EDITORIAL BOARD OF THE JOURNAL

A report from the Subcommittee on the Operation of the JOURNAL was presented in manuscript form in the absence of the Chairman of the Committee, Dr. Marvin. The report made nominations to the Editorial Board of the JOURNAL as it would be if the proposed amendments to the By-Laws are adopted by the House of Delegates on April 27, 1954.

The committee made no nominations for the office of Literary Editor and Chairman of the Board as provided in the By-Laws. It was voted to approve the nominations made by the committee and to request that it present an additional report to the next meeting of the Council making a nomination for Literary Editor and Chairman of the Board.

## DUES EXEMPTION

A communication from the secretary of the Hartford County Medical Association in regard to confusion and possible unfairness arising in connection with the exemption from the payment of dues for certain members of the Society was reviewed (AMB 3/11/54 "F") and referred to the treasurer and executive secretary to develop a plan so that inequities of this kind will not arise in the future.

## CONFERENCE OF PRESIDENTS

It was voted that the Society continue its membership in the Conference of Presidents and other officers of state medical associations and that the dues for 1954 in the amount of \$75 be paid.

## CMS REPORT

Dr. Danaher submitted his report as chairman of the Professional Policy Committee and member of the Board of Directors of Connecticut Medical Service that he would present to the House of Delegates on April 27. The report was discussed and no action was necessary or taken. (AMB 3/11/54 "G")

## RESOLUTIONS ON CMS

Three resolutions concerning Connecticut Medical Service submitted by Dr. Samuel Spinner of New Haven for action at the House of Delegates meeting on April 27 were presented and discussed. No action was taken. (AMB 3/11/54 "H")

A resolution concerning Connecticut Medical Service submitted by the Board of Governors of Hartford County Medical Association for action by the House of Delegates on April 27 was presented and discussed. No action was taken. (AMB 3/11/54 "I")

## STUDENT MEMBERS ELECTED

Richard J. Cobb, West Hartford  
New York Medical—Class of 1957  
Pre-Med: Providence College  
Parent: Charles W. Cobb

Lewis Arthur Dalburg, Jr., New Britain  
New York Medical—Class of 1958  
Pre-Med: University of Maryland  
Parent: Lewis Arthur Dalburg, Sr.

Michael Leonard Daly, Jr., Hartford  
New York Medical—Class of 1957  
Pre-Med: Trinity College  
Parent: Michael L. Daly, Sr.

Kevin V. Dowling, West Hartford  
New York Medical—Class of 1957  
Pre-Med: Georgetown University  
Parent: Victor H. Dowling

Robert Anthony Michalski, New Britain  
Cornell Medical—Class of 1957  
Pre-Med: Cornell University  
Parent: Anthony F. Michalski

Allen Wesley Morrissey, Stratford  
New York Medical—Class of 1957  
Pre-Med: University of Connecticut  
Parent: Richard E. Morrissey

Manuel Joseph Soares, West Hartford  
New York Medical—Class of 1957  
Pre-Med: Trinity College  
Parent: Manuel Soares

Mark Anthony Lolatte, Jr., Stratford  
New York Medical—Class of 1957  
Pre-Med: Fairfield University  
Parent: Mark A. Lolatte, Sr.

Charles John Zmijeski, Jr., New Britain  
New York Medical—Class of 1957  
Pre-Med: Fordham University  
Parent: Charles Zmijeski

Donald Fowler Bradley, Jr., Cheshire  
New York Medical—Class of 1957  
Pre-Med: Yale  
Parent: Donald F. Bradley

Albert Coleman Hurwit, West Hartford  
New York Medical—Class of 1957  
Pre-Med: Harvard  
Parent: Benjamin J. Hurwit

Sidney Harold Widrow, Versailles, Conn.  
Harvard Medical—Class of 1957  
Pre-Med: Dartmouth  
Parent: Moses Widrow



## Meetings Held During March

- March 4—Woman's Auxiliary—New Haven County
- March 5—Connecticut Health League
- March 5—Program Committee, Connecticut Clinical Congress
- March 9-10—Connecticut Medical Examining Board
- March 11—Council Meeting
- March 11—Committee on Public Health
- March 16—Cancer Coordinating Committee
- March 18—Committee on Public Relations
- March 23—Committee on State Blood Bank
- March 23—Connecticut Medical Examining Board
- March 24—Committee on Maternal Mortality and Morbidity
- March 24—Conference Committee with State Bar Association and State Dental Association
- March 25—Committee on School Health
- March 31—Committee to Study Neonatal Mortality

## Blue Cross Meets National Enrollment Record

Connecticut Blue Cross membership—1,200,000 strong—has reached a national record for health care plans. With the addition of more than 90,000 new members since the first of the year, the non profit hospital plan now lists sixty per cent of all men, women and children in the State on its membership rolls. Although states with metropolitan centers like New York, Philadelphia and Boston can claim a higher grand total, only Rhode Island matches Connecticut for covering so large a percentage of its citizens.

Enrollment of United Aircraft Corporation, Connecticut's largest employer, boosted Blue Cross to the record making figure. Plan benefits began March 1 for workers and family members who signed up for Blue Cross Comprehensive coverage through the Pratt & Whitney plants at East Hartford, Southington, Meriden and North Haven when the aircraft company recently installed a new group insurance program. The Hamilton Standard Division at Windsor Locks will complete its enrollment later this month.

The New Haven area, birthplace of Connecticut Blue Cross 17 years ago, leads the State in local membership, with an estimated 78 per cent of its residents Blue Cross enrolled. Wide acceptance by

industrial workers in New Haven and Waterbury when the plan was started gives that area a slight edge over Hartford county, where approximately 71 per cent of the population now budgets hospital expense through Blue Cross.

In the Fairfield county region, membership centers largely around Bridgeport, Norwalk and Danbury with similar heavy enrollment in Torrington and Winsted. Blue Cross coverage in these areas is estimated at about 51 per cent of the population total. Several other Connecticut cities with heavy industrial employment have also passed the 50 per cent mark. These include Bristol, Meriden, Middletown and Manchester.

Bringing hospital plan benefits to the rural sections of northern and eastern Connecticut presented a real problem in the early days of Blue Cross. In recent years, however, cooperation from the State Grange and Farm Bureau groups has put Blue Cross on the rural routes too. Periodic direct enrollment drives have also helped to spread membership among families outside the reach of business and industrial groups.

## A REQUEST for CHANGE OF ADDRESS

... must reach us at least three weeks before the date of issue with which it is to take effect. Duplicate copies cannot be sent to replace those undelivered through failure to send such advance notice. With your new address be sure to send us the old one, enclosing, if possible, your address label from a recent copy.

**CONNECTICUT STATE MEDICAL JOURNAL**  
160 St. Ronan Street New Haven 11, Conn.

## Foreign Trained Doctors Creating Problem

Licensure and medical care problems created by the heavy influx of foreign trained doctors commanded a great deal of attention at the 50th annual Congress on Medical Education and Licensure in Chicago, February 7-9.

The three day meeting attracted an unexpectedly heavy attendance of more than 600 medical educators and licensing and specialty board officials. The congress was sponsored by the American Medical Association's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States, and the Advisory Board for Medical Specialties.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, dean of Columbia University College of Physicians and Surgeons, told the meeting.

"The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government, in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of 40 years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of 50 years ago.

Dr. Stiles D. Ezell, Albany, secretary of the New York Board of Medical Examiners, also called attention to the inadequacy of the medical training of most of the foreign doctors seeking to practice in the United States.

Dr. Ezell said that, except for Great Britain and the Scandinavian countries, the last war brought destruction and degeneration to European medical education.

"Even before the elimination of the last of the unapproved medical schools in this country, there had begun a migration of physicians to this country which has now reached a total of more than 20,000,"

he stated. "The challenge in this fact is that the profession has not been prepared to understand what is involved in such a massive movement, nor has it realized the numerous deficiencies involved in the collective educational background of this group."

He pointed out that large numbers of foreign graduates have completed specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure.

Dr. Edward L. Turner, Chicago, secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign trained doctors.

Such a uniform procedure, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Turner reported that the Council on Medical Education and Hospitals and the executive council of the Association of American Medical Colleges have compiled a list of 39 foreign schools which provide basic medical education on a par with that of approved schools in the United States, but said there are more than 550 medical schools in the world.

He said that while the council has endeavored to indicate that the absence of a school from this current listing does not indicate either approval or disapproval, but means primarily lack of adequate information, the absence of listing frequently serves to deny a graduate the right to examination before a state board.

"It seems advisable that there should be a careful analysis of state medical practice acts with serious consideration being given to the cooperative development of some commonly acceptable yardstick or screening mechanism to evaluate competence of the foreign graduate," Dr. Turner stated.

He suggested that the National Board of Medical Examiners could become a highly effective aid to state boards in determining whether foreign trained physicians were eligible for further state board consideration for licensure. The National Board, at the request of the state board, could conduct the examination for professional competency, and the state board could then determine if the candidate met other requirements for licensure, he added.



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## Special Article

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### VETERANS MEDICAL CARE

### Physicians Attitudes and Responsibilities

RUSSELL B. ROTH, M.D., *Pittsburgh*

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The Author. *Member, Board of Trustees and Councilors, Medical Society, State of Pennsylvania*

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WE OF the medical profession have a clearly defined sphere of responsibility, magnificently phrased by Sir Thomas Watson, and incorporated in our Principles of Medical Ethics. May I repeat it for you? "The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its clients' cause, but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party, and rank, and religion, and to men of no religion at all." There is little need to elaborate upon that. We are committed to strive for the provision of proper medical care to all who have need of it—in all the cities, towns, and hamlets that comprise our States and our Nation. We are pledged to resist all efforts to create barriers of discrimination, not only in terms of race and creed, but in terms of any artificial distinction. It is our collective responsibility to work for equal opportunities for the health of all Americans.

This, of course, is not an attitude singular to the medical profession. It is an expression of intent basic to most of the worthwhile professions and institutions of our nation. Our new Chief Justice, on the occasion of his recent appointment said, "If through the years our work is well done, the home of every American will always be his castle, every human life will have its dignity, and there will forever be one law for all."

It would seem to be an overwhelming trend in this country to direct our steps away from castes and classes. Only in isolated instances, dictated by fears concerning political expediency, have our lawmakers

#### SUMMARY

The medical profession is the champion of the cause of all who are sick and afflicted, regardless of caste or class. Certain veteran nonservice cases are established by law. Determination of the expected cost of any illness is a difficult matter. Except for NP and TB cases, veterans who are able should pay for their care when suffering from nonservice disabilities. Most of the real criticism of the VA program comes from physicians engaged in VA medical work. The attitude of the part time VA physician and of the medical school faculty group is considered. The AMA program opposing VA care of veterans with nonservice connected disabilities is not a fight against the veteran or against any veterans' organization but against the inequities of the present costly system and for a system which is in the best interests of all the people.

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shown any inclination to indulge in the creation of new strata of privilege.

We need to stress this point that we are the champions of the cause of all who are sick and afflicted, because we are going to be accused of being against the veteran who is sick, broke, and has no place to go. We are going to be accused of being antiveteran, in spite of the fact that those of us who are most active in this matter are, almost to a man, veterans ourselves. It is my belief that no profession or organization in America today exceeds us in acute awareness of the magnitude of the contribution made by the members of our Armed Forces in preserving the identity of the United States and the free nations of the world. If this contribution may be measured in terms of suffering and death, who is better qualified to assess it than those who shared the perils and

labored so effectively to allay that suffering and avert that death? We of the medical profession, veterans ourselves in overwhelming majority, are among the least likely to countenance forgetfulness or condone ingratitude. It is my belief that we can win recognition from all fair minded men that we are for the fellows who are sick, broke, and have no place to go, veterans included.

There are certain real problems that arise in the effort to avoid injustices. First, there is the difficulty of determining what is and what is not service connected. No set arbitrary rules will ever solve this. Congress has said that anything whatsoever which happens to a veteran of the Spanish-American War is to be treated as though service connected, and that is that. Not very scientific perhaps, but clear cut. Congress has likewise established by legislative fiat that in the case of certain diseases becoming apparent within a fixed time after discharge service connection may be presumed. Again obviously right in many cases, wrong in some cases—but at least definite. Beyond these legally defined instances, the decision as to service connection must be made by medically educated individuals of a disposition to be as fair as possible, always with the inclination to give the benefit of the doubt to the sick man. Such boards are bound to make some mistakes—in each direction, because all too often the underlying causes of illness are still obscure.

Next, there is the matter of determining what a given illness will cost. Regardless of what one may think of the ethics and morality of a means test for veterans, it does not make good sense to ask a man whether or not he can afford the costs of civilian care for his illness when he has not the vaguest idea of what that cost may turn out to be. There is, of course, a predictable cost range for the care of many illnesses, but it is manifest nonsense when dealing with people suffering from as yet an undiagnosed disease. Complications are usually unforeseen. Hospital charges vary, doctors' fees vary, and length of hospitalization may vary in inverse ratio to the determination of the patient to get well and get back to work. The most difficult area for determination of the cost of illness lies in the matter of predicting the range of necessary follow-up care, brief in many instances, life-long in others. It is for these reasons that the AMA feels forced to adopt the attitude that a pauper's oath or means test should be no part of the consideration. Either a veteran is entitled to free care on the moral grounds that his disability

was incurred in or aggravated by service, or he is not entitled to such free care. As distinctly as possible it should be made a matter of black or white, with the intermediate gray areas being composed of only those cases in which the service connection is not clear. Financial status should have no part in the matter. It is a temporary abrogation of this principle to make certain exceptions—fundamentally undesirable, but dictated by the practical fact that in civilian life there are as yet inadequate facilities for the care of all who have tuberculosis or N-P disorders, but in the VA there are facilities far beyond those required for the care of service connected cases. In consequence, it makes practical sense to endorse the use of these facilities by those who cannot purchase private care, since these cases are known to be long-term disabilities.

The AMA must then go on to advance the view that the veterans' organizations are not broad enough in their own viewpoints. Veterans' organizations are strong for Americanism. They should not say that only veterans are entitled to adequate medical care under any and all circumstances. They should champion the cause of all who are sick and afflicted. They should work, along with the medical profession, for that Utopian situation in which adequate medical facilities will be available to all who need them, under circumstances in which those who can afford to pay for them may appropriately do so, and those who cannot meet the bills will have them paid at taxpayers' expense. The veterans' organizations would do better to lend their efforts to ever greater protection against the costs of illness through voluntary insurance, even as the unions have done, than to clamor for tax-paid, free handouts on a discriminatory basis.

Next, we must get the economics of this situation straight. It is widely assumed, even by many who side with us, that our major concern is for our own pocket books. Emphasis has been placed on the fact that there are some veterans receiving free medical care who by every reasonable yardstick ought to be purchasing that medical care from civilian doctors in civilian institutions. It is my feeling that if we enlist the support of the medical profession with that as the principal motivation we are likely to be guilty of misrepresentation. Adherence to the AMA policy, actually, is likely to represent an economic loss to the profession. We are asking the government to stop paying doctors—and we are the doctors—for taking care of a major share of the 85 per cent



nonservice connected admissions to the VA hospitals. We expect to collect from those who really can pay for their care, in spite of the fact that they swore they could not on admission—but even the American Legion says this will not amount to more than 10 per cent of the cases in question. Some of the remaining 75 per cent, if they are N-P or TB cases, we wish to leave in VA hands until adequate civilian facilities are available, but the rest we ask the opportunity to care for in civilian institutions—largely without recompense—at least in terms of dollars and cents. I am asking that the government quit paying me a nice consultant's fee for two visits a week to the VA hospital to care for patients that are almost without exception nonservice connected. I am asking that those few who can pay for their services do so—not necessarily to me, but to any civilian urologist to whom they may be referred. I am asking that the rest of these patients be cared for on a part pay basis in our civilian institutions. I am asking to forego a substantial sum each year that the VA has been paying me, and I am joined by most other consultants and attending VA physicians. By the same token, if there is to be well over 50 per cent reduction in the volume of patients in the VA system, there will be many less full-time VA physicians required. Some of our fellow physicians in the VA may be expected to oppose our stand for no other reason than a fear of the loss of their jobs. We have little to say to these doctors that will sound persuasive, except to assure them that any doctor worth his salt can make a decent living in this day and age. There are many other institutional jobs available if it is institutional medicine they feel they must pursue. There are many communities that need and want and will support a physician if he will forsake his duty hours and his institutional security and undertake the rigors of civilian free enterprise practice. Actually, it would appear that resistance to the AMA policy is not destined to be large. Much of the most sincere and searching criticism of the VA program comes from the men doing the VA medical work. It is at once obvious that they not only know the problems most intimately, but by the very nature of their positions they find it impractical to make their sentiment known loudly.

It is worth a moment of our time to digress a bit on this subject. The will to get well is a very important factor in the battle against disease and disability. A dogged determination to be rehabilitated is often the *sine qua non* of rehabilitation. In

psychiatric practice it is almost axiomatic that insight and a compulsion to recover are necessities in treatment which go hand in hand. Many a VA physician has felt that his task has been made immeasurably harder when he has to deal with patients who are content to accept their lots, taking comfort that they are not being a burden to anyone, that free care is theirs for as long as necessary, and that the stresses and realities of outside life do not need to be faced. Those who have supervised free service in hospitals of any kind know only too well that there are many patients who set great store by warm quarters, a good bed, three square meals a day, and an attentive staff. They are more anxious to prolong their stay in such surroundings, even if they have to invent new complaints to justify it. The doctor who forces the discharge of such a patient is made to feel that he is being heartless indeed.

The attitude of those working as part-time VA consultants or attending physicians seems to be reasonably clear. The bulk of the men working for needed reforms in the system are those who have seen it from this vantage point. The inequities are perhaps more apparent to them than to anyone else. They see the contrast between the length of hospital stay for a patient in the VA hospital, and the patient with the same condition in a civilian hospital. They see the fully insured chap with a good job who has blandly signed the paupers' oath. They are the ones best qualified to appraise the inroads made by the VA on the local supplies of nurses, technicians, and other ancillary medical personnel to the detriment of the civilian hospitals. They are most acutely aware of the threefold greater value of the medical care dollar in civilian hands than in Federal hands.

The vast majority of doctors, of course, have no direct contact with the VA. Those in areas remote from VA facilities are likely to have had no sense of impingement on their practices. They may have looked on the VA hospitals as a convenient place to ship a few of their more troublesome cases. Among them there is likely to be apathy and indifference which we must attempt to dispel. Those doctors working in areas served by VA hospitals are likely to be more alert to the problem, even if it be only on the level of the economic competition involved. One of our local doctors who does general surgery vented a little indignation on this score in an income tax discussion recently. He said, "You know, I'm about as big a sucker as ever comes along. I pay a nice round sum to the government to help

them build and operate a hospital up here and pay a salary to a surgeon to take my business away from me. I'm financing my own competition." This, of course, is grist for the mills of those who would accuse us of being mercenary, but it is a nonetheless defensible attitude.

Perhaps the most unpredictable group among physicians is the medical school faculty group. Some, resenting the siphoning off of clinical material from their own teaching services, stress the detrimental effect of the VA on medical education. Others, concentrating attention on the residency training programs instituted in some of the VA hospitals, and considering the lightened burden on their civilian institutional budgets, stress the good. The basic decision to make, however, is whether or not medical education is a proper function of the VA. Most of us feel that it distinctly is not.

We do not believe that too much should be made of the point raised by some critics of the VA that veterans are now becoming the guinea pigs of medical education. Well ordered residency training programs do not make guinea pigs of anyone, but to remain well ordered programs we must stress that they should be retained in the teaching hospitals of the nation under the control of civilian physicians, and for the most part closely allied with our medical schools. We should take no chances that veterans might be subjected to less conscientious and conservative care than has traditionally been accorded to the patients of our teaching hospitals. We must wholeheartedly reject the inverse sort of reasoning which says we cannot decrease the VA hospital load because we would lose the clinical material essential to our growing residency training program. When a VA hospital loses sight of its prime objective of giving the finest possible care to those who so completely deserve it, the whole program will have strayed far from its purpose. Service connected illness and disability should be diagnosed and treated by fully qualified experts—not by trainees—else we are not doing all that a grateful nation should do in behalf of those who deserve the best.

I have already stressed that this program of ours is not a fight against the veteran, or against any veterans' organization. It is also most assuredly not a fight against the VA. The present achievements of the VA are good and great only because of the wholehearted cooperation of the medical profession. We are not selling short the calibre of VA care. It

has been excellent in recent years. We do observe that it is inefficient and inordinately expensive, but it is good. It is monstrous to think of an expansion of the VA system to provide all medical care to all people and that, after all, is our primary concern. That which the government and the VA and the medical profession have done is good, but there are better things to do. Our energies and our resources should be dedicated to a system that has some ultimate chance of being in the best interests of all the people. Whatever may happen to the VA hospital system, there will be an unresolved need for local medical facilities. It is not within our concept of that which is practical or desirable to create two huge overlapping systems of medical care—one for veterans, and one for those who are not veterans because they were too young, too old, or the wrong sex, or physically unacceptable, or in essential civilian work. The American medical profession has made its choice which is to promote a program for adequate medical care for all, veterans and non veterans alike.

This is not a policy dictated by self interest, nor even primarily in the interests of national economy. That civilian medical care program will cost money—huge sums of money. Hospitals need to be constructed—to serve all the people. Those who cannot afford care must be cared for—at taxpayers' expense. We are advocating more medical care than the VA is proposing, because we aim to serve more people and to do it within a system characterized by efficiency, economy, and equality.

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### Governor Lodge Appoints Four Physicians

Four doctors were named by Governor Lodge to represent him at a Chicago conference March 18 to 20 on the care and treatment of the chronically ill sponsored by the National Commission on Chronic Illness.

Appointed by the Governor to attend the three day session were: Drs. Sidney Shindell, medical director of the Commission on the Chronically Ill, Aged and Infirm; James Raglan Miller of West Hartford, a commission member; Harold S. Tuttle, chief of the section on medical services in the State Health Department and Harold S. Barrett, deputy state health commissioner.



## CONNECTICUT AMEF CAMPAIGN-1954

The 1954 Connecticut campaign to help meet the needs of our medical schools will soon be underway.

A series of direct mailings will comprise the main effort of the campaign and all physicians are urged to support this important cause.

Besides graduating 6,500 new physicians annually, our medical schools:

- \*Teach 27,000 undergraduate medical students.
- \*Conduct refresher courses for 17,000 practicing physicians.
- \*Train 11,000 graduate physicians, residents, and interns.
- \*Teach 8,000 non medical students taking medical courses.
- \*Instruct 16,000 dental, pharmacy, nursing and technical students.
- \*Direct research projects costing \$32,000,000.
- \*Function as centers for the advancement of medical science and development of new techniques.

Administrative costs of the campaign are underwritten by the State Medical Society and the American Medical Association. Every dollar contributed goes to medical schools.

Medical Education  
Needs Your Help

## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold J. Bergendahl, Norwich

James C. Canniff, Torrington  
Morris A. Hankin, New Haven  
Harry C. Knight, Middletown

John O'L. Nolan, Hartford  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

### Connecticut AMEF Report Given National Distribution

Copies of a report on the organization of the 1953 Connecticut Campaign for the American Medical Education Foundation are to be mailed to all state AMEF chairmen by the Foundation's Chicago office.

The plan was recently announced by Hiram W. Jones, the Foundation's executive secretary, as part of a program to inform AMEF committees concerning campaign organization and operation.

The campaign was based on personal contact by teams of physicians in their own communities. The plan called for three phases of operation, with appropriate letters of procedure, information kits and organizational aids, as follows:

#### FIRST PHASE—FOR COUNTY PUBLIC RELATIONS CHAIRMEN

Required organization of each county into campaign districts and appointment of volunteer leaders for each district. Direct contact with district leaders was established by the state committee as soon as notification of appointments was received.

#### SECOND PHASE—FOR DISTRICT LEADERS

Required appointment of team members to conduct the campaign in each district, based on average of ten to fifteen physicians to be contacted by each team member.

#### THIRD PHASE—FOR TEAM MEMBERS

Required personal contact of physicians listed on contribution cards supplied by district leaders. A campaign kit prepared for this phase furnished team members with factual information useful in answering questions that might arise.

In addition to the three operational phases, the campaign was promoted in the following ways:

1. A direct mailing to physicians early in December to encourage those who had not already done so to contribute before the end of the year.

2. Full page appeals in seven issues of the CONNECTICUT STATE MEDICAL JOURNAL.

3. Presentations at annual and semi-annual meetings of county medical associations.

4. Field meetings in several counties to assist in completing the campaign.

5. Distribution of AMEF Handbook on Medical Education.

More than 150 members of the Society, ranging from members of the Public Relations Committee to district leaders and team members helped to conduct the 1953 campaign. The total contributions amounted to \$8,498 from 425 physicians, with an additional amount to be credited for checks mailed directly to medical schools and not yet tabulated.

### Hartford County Service for New Residents

New residents in the Hartford-New Britain area are informed concerning the availability of medical care in emergencies in a personal letter from the president of the Hartford County Medical Association.

A blotter imprinted with the call number of the emergency plan is enclosed for ready reference. A considerable number of new families continue to arrive in the area and approximately 150 letters are mailed from the Association's office each month.

In addition to informing residents of the emergency service, the letter urges early selection of a family physician as the best safeguard. Residents are invited to call the office of the Association at any time questions may arise.

### Medical Society Course for Office Personnel

A course for medical office personnel sponsored by the Spokane (Washington) County Medical Society is now in its third year of successful operation. It provides a pattern for associations interested in conducting similar training programs.



Meetings are held one evening each month on such topics as use of the telephone, credits and collections, personal appearance, industrial insurance and office procedure.

Attendance is voluntary and those who attend

eight of the conferences receive certificates of completion. The course is well publicized and enrollees also include members of the Visiting Nurse Association of the City Health Department and students pursuing medical secretarial training.

## MILITARY AFFAIRS

### COMMITTEE ON MILITARY AFFAIRS

COLE B. GIBSON, Meriden

STANLEY B. WELD, Hartford

HAROLD SPEIGHT, Middletown

### All Obligated Physicians Due for Active Service by July 1, 1955

During the next fiscal year, starting July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: 1. If given free choice, which service would you prefer? 2. Do you prefer to serve

your time immediately following internship? 3. Or following internship and one year of hospital training? 4. Or following full residency training? The results showed 27 per cent of the students preferred the Army, 37 per cent the Navy and 36 per cent the Air Force. Thirty-nine per cent preferred service immediately following internship, 15 per cent preferred it after two years of hospital training and 46 per cent preferred military duty after full residency training.

### Enlisted Status Proposed for Some Physicians

To make it possible to use suspected subversive physicians and dentists in noncommissioned rather than commissioned status, Defense Department is asking for new legislation. The bill, an amendment to the Doctor Draft act, would authorize the services "to utilize in his professional capacity in an enlisted grade or rank . . ." any person drafted or called to duty "who fails to qualify for or accept a commission, or whose commission is terminated." The bill is awaiting Budget Bureau approval. A recent Court of Appeals decision ordered the Army to commission or discharge Dr. Herbert L. Nelson, a dentist, who refused to fill out his loyalty questionnaire. The now celebrated case of Dr. Irving Peress, another dentist, is similar, except that in this instance the Army kept him on duty as a commissioned officer after learning that he had not filled out the loyalty questionnaire. (Defense Department has announced it will need about 4,500 physicians for the fiscal year starting next July 1.)

## NEWS FROM WASHINGTON

### Administration's Reinsurance Plan Introduced in Congress

Bills to carry out the Eisenhower administration's plan for reinsuring prepaid health insurance plans were introduced in House (HR8356) and Senate (S3114) on March 11. In explaining the program, the Department of Health, Education, and Welfare said:

"The program would not reinsure . . . a particular policyholder nor . . . a carrier as such. It would protect the carrier against bad experience in the aggregate under a particular reinsurance plan. Only abnormal losses and those in excess of anticipations would be reinsured. . . . The carrier would share in paying these abnormal losses (U. S. share limited to 75 per cent) . . . . The program is designed to encourage carriers to experiment more broadly and rapidly. . . . Success would depend entirely on voluntary action by (carriers)."

The program would be started with a federal appropriation of \$25 million. The objective is to make the fund self sustaining within five years by scaling premiums to match expenses, with the U. S. advance to be repaid. The federal obligation would not extend beyond the money in the reinsurance fund, or in separate funds if they are established.

Responsibility for administration would rest with the secretary of HEW, who would also fix rates of reinsurance and could cancel contracts for cause. State insurance authorities would be used to the maximum extent, including enforcement of compliance with regulations.

#### PLANS ELIGIBLE

Private insurance companies, voluntary nonprofit associations such as Blue Cross and Blue Shield, and other voluntary groups could participate if approved by the secretary and if they complied with conditions and standards, including those noted below.

#### REQUIRED OF PLANS

The secretary would establish terms, conditions and requirements for types of plans, taking into consideration these objectives: extension of coverage to persons not now protected, extension to new geo-

graphic areas and provision of benefits and services not now readily available. Plans would not be approved unless (a) financially sound, (b) operating according to state law, and (c) worthy of public confidence. The secretary would specify minimum benefits and waiting periods, and set up safeguards against undue exclusions based on such things as pre-existing conditions and specific illnesses. Plans of a given kind or type could be reinsured only if reinsurance, on comparable terms and conditions, were not available from private sources.

#### FEDERAL COUNCIL AND TECHNICAL SERVICE

A National Advisory Council on Health Service would be established, consisting of 12 members four of whom would have to be experienced in the administration of health plans. Appointments would be by the secretary. The Council would advise, consult with and make recommendations to the secretary. The Department of HEW also would maintain a technical advisory and informational service to assist health plans without cost. The information service would conduct studies and collect and distribute information on the organizational, actuarial, and other problems of health insurance.

### Manion Commission Starts Survey of Grants in Five States

On contract from the Commission on Intergovernmental Relations, private research organizations have started a study of five states "widely representative of the national picture" to determine the impact of federal aid programs on state and local governments. The states are Kansas, Wyoming, Michigan, Mississippi, and Washington. Twenty-two federal grant programs representing 87 per cent of the nearly \$3 billion spent annually for all federal aid will be investigated. Included will be hospital construction, general public health, venereal disease, tuberculosis, mental health, cancer, heart disease, and housing and slum clearance. The commission explains: "The surveys are expected to enable the commission to recommend what functions, if any, should be reallocated as between the federal, state, and local governments, and what modifications of existing procedures in the federal aid programs are



necessary to eliminate overlapping, unnecessary controls and excessive costs."

In the health field, the principal grant-in-aid programs are carried on by the Public Health Service and the Children's Bureau. Grants from the Public Health Service are provided for tuberculosis, mental health, general health, heart disease, and cancer control, among others, while the Children's Bureau allocates funds for services for crippled children and maternal and child health. Vocational rehabilitation and, of course, the Hill-Burton hospital program also are conducted on the same basis.

Some of the basic questions which must be answered concerning medical grant-in-aid programs are:

1. Should federal funds be reduced or eliminated for all or any one of them?
2. Should federal funds be maintained at the present level or increased for all or any one of them?
3. If federal funds are reduced or eliminated, can the services rendered be supported by state and local tax revenues?
4. If you believe federal funds should be eliminated, should the process be gradual to permit local governmental jurisdictions to assume the responsibility?
5. If federal grants-in-aid should be continued in any or all of the existing programs, should the grant-in-aid formula be changed?
6. Should the federal-state administrative relationship presently established by federal regulation be altered in any way?
7. Which, if any, of the grant-in-aid programs should be considered a proper federal responsibility?

The Manion Commission has been granted another year (until March 1, 1955) in which to complete its work.

### **If Doctors Pool Fees, They're (Tax) Partners**

Ruling by Internal Revenue Service holds that if members of a hospital staff pool fees received from patients, for subsequent distribution among themselves, they comprise a partnership and the group must file a partnership tax return (Form 1065). IRS ruling resulted from inquiry that was made by staff members of an unnamed hospital. Their fee collections came from part-pay ward patients. Each "partner," under IRS ruling, is required to report

as taxable income "his distributive share of the net income of the organization for the taxable year ending with or within his taxable year, whether or not distributed, even though it may reflect certain amounts retained by the organization as a reserve for expenses."

Another recent tax ruling: One may not deduct, under heading of medical expenses, sums expended for building a swimming pool or installing an elevator on taxpayer's property, even though these features were recommended by a physician for purpose of conserving or protecting health.

### **Federal Employee Health Insurance Proposed**

President Eisenhower has announced that later in the session Congress will be asked to set up a program of contributory medical care and hospitalization insurance open to all federal employees, and supported in part by an annual contribution of about \$50 million from the U. S. government. Payroll deductions, presently forbidden under federal law, would be authorized. The plan is reported to include these other points: 1. The government and the employee to share equally premium costs up to \$25 per year per employee, with the latter paying all costs above that figure. The employee would have his choice of hospitalization, surgical care and medical care, or all three, for himself and his family, but the U. S. contribution would not exceed \$12.50. 2. Private insurance groups—Blue Cross and Blue Shield, White Cross, and cooperative group health plans—would handle the insurance. There would be no set formula, but details would vary among departments and geographic areas. The administration also is proposing that Congress authorize federal contributions toward life insurance policies for U. S. employees.

### **Congress Receives Results of Bolton Poll on Nurse Shortage**

The nurse shortage in the U. S. is acute and remedial action is urgently needed, Rep. Frances Bolton (R—Ohio) has informed Congress. Her findings were reported to the House as a result of a poll sent to 10,000 nurses, physicians, hospital administrators, state and federal officials and other interested laymen. Mrs. Bolton reported she had received returns from 38.5 per cent of those sent questionnaires. Mrs. Bolton introduced a bill early in the last session for

a federal program of grants for graduate nurse training and practical nurse training. The American Medical Association, in testimony to the House Commerce Committee, reiterated support of one-time construction or renovation grants to nursing schools on a matching basis and grants to states for advanced nursing scholarships.

Mrs. Bolton listed these findings, among others, in her report to the House: (1) Nurse shortage is most critical in general and private duty nursing, followed by teaching, supervision and administration categories, (2) low pay and long and irregular hours are major factors in the shortage, (3) more funds to nursing schools should remedy the shortage, and (4) a program of state administered, federal-state matching funds is the preferred approach to the problem.

### **New Hill-Burton Expansion Bill is Reported to House**

The House Interstate and Foreign Commerce Committee on March 3 favorably reported a new bill (HR8149) for expanding the Hill-Burton hospital construction program to include diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation centers and nursing homes. It supersedes HR7341. The same appropriations are asked: \$182 million over three years, with \$2 million for planning and surveys, \$20 million annually for diagnostic or treatment centers, a like amount for hospitals for the chronically ill, \$10 million for rehabilitation facilities and a like amount for nursing homes. Administration (by states, under regulations drawn up by the U. S. Surgeon General) would remain generally the same as in HR7341. The changes include:

U. S. Share. Under the earlier bill, states would have been required to match federal money dollar for dollar. The new bill adopts the regular Hill-Burton procedure for matching, except that a state may decide on a 50-50 matching program. ". . . For All the People." The new bill restates the purpose of the original Hill-Burton law to help states to provide facilities "for furnishing to all their people adequate services." It is understood that this would rule out facilities sponsored by a labor or fraternal organization or a prepaid health plan unless the general public were allowed full and unrestricted use of the facilities. "Nonprofit" and "Public" Requirements. The first bill limited grants to "nonprofit" centers or hospitals. The second changes this

to read "public and other nonprofit" centers or hospitals. The earlier bill required that centers and nursing homes be "under the professional supervision of persons licensed to practice medicine in the state." The second broadens this by also making eligible centers and nursing homes that are "operated in connection with a hospital." Restriction on Diagnostic-Treatment Centers. A new restriction is written into the bill concerning diagnostic or treatment centers. If they are not public, they would have to be operated by or be a part of "a corporation or association which owns and operates a nonprofit hospital." This would bar U. S. grants to a group of physicians who want to set up a center, unless they also operate a nonprofit hospital. Bi-State Facilities. Under the new bill it would be possible for a state to have a portion of its allocation transferred to another state to help in the construction of a facility for use of both states. Restriction on Disposition. The first bill would have authorized the federal government to recover its proportionate share of a facility converted to private profit use within 20 years after construction. The new bill would allow the U. S. to recover if the facility were sold or transferred at any time.

### **New Senate Legislation**

#### **S2759—Amends Vocational Rehabilitation**

**Act.** (Smith, R—New Jersey, January 19.) An Administration bill based on the President's health message to Congress. The bill would substitute for the existing Vocational Rehabilitation Act a new act authorizing appropriations to assist in the rehabilitation of handicapped persons in three ways: (1) Grants to states to meet the cost of rehabilitation services, (2) Six year grants to states to extend and improve rehabilitation services, and (3) Grants to states and to public and other nonprofit organizations and agencies to meet the cost of unique projects directed toward the solution of regional or national rehabilitation problems. During the fiscal years 1955 and 1956 special project grants would be available for helping the states to plan and initiate a substantial expansion of their vocational rehabilitation programs.

The bill is not intended to provide grants for major new construction.

Each state would have a minimum allotment for general grants of \$50,000 with the federal share varying from 33⅓ per cent to 66⅔ per cent.



Extension and improvement grants would carry a minimum allotment of \$5,000 per state with the federal share up to 75 per cent of the cost for the first two years, 50 per cent for the next two, and 25 per cent for the last two years.

Payments under the unique project grants would be determined by the Secretary of Health, Education, and Welfare. To receive federal approval of a plan, a state would designate a single administering agency and provide for personnel and administration standards to be approved by the Secretary of HEW. The state agency would agree to cooperate with the Bureau of Old Age and Survivors Insurance, the state agency administering the state's public assistance program, and other bureaus providing vocational rehabilitation services.

Because of the new allotment and matching formulas, there would be a limit of 10 per cent for any decrease in allotments to a state in any one year.

These amendments would become effective July 1, 1954. To Labor and Public Welfare Committee.

**S2778—Amends Public Health Service Act.** (Smith, R—New Jersey, January 20.) The Administration bill, promised in President Eisenhower's health message, to extend and improve public health services by a better use of federal funds.

The bill would replace the present separate authorizations for grants to control individual diseases with an authorization for the following three types of grants: (1) Grants to assist states generally in meeting the cost of their public health services, (2) Six year grants to assist states to extend and improve their public health services, and (3) Grants to states and to public and other nonprofit organizations and agencies to meet the cost of unique projects directed toward the solution of regional or national public health problems.

The type of grants are similar to those in the Administration's vocational rehabilitation bill (S2759).

In the general or type (1) grant the financial aid formula would be based on a state's relative population and fiscal resources as measured by the state's per capita income (this is the formula used in the Hill-Burton Hospital Construction Act). Each state would have a minimum allotment of \$50,000 with the total federal share varying from  $33\frac{1}{3}$  per cent to  $66\frac{2}{3}$  per cent. Payments from

allotments would depend upon submission by the state health authority of a plan meeting federal requirements.

The extension and improvement or type (2) grant would carry a minimum state allotment of \$25,000 with the federal share up to 75 per cent for the first two years, 50 per cent for the next two, and 25 per cent for the last two.

The unique project or type (3) grant would be made by the Surgeon General from money available for any fiscal year. Payments would be made in advance or by reimbursement for services and purchases determined by the Surgeon General as necessary to carry out the unique project.

To permit states to adjust their finances to the new allotment formulas, there would be a limit of 10 per cent for any decrease in allotments which a state would receive in any one year.

The act is to take effect July 1, 1955. This bill is identical with HR7397 introduced the same day in the House. To Labor and Public Welfare Committee.

**S2929—Social Security Increases.** (Long, D—Louisiana, February 10.) Amends Social Security Act to increase federal money in state programs (because of higher living costs) for old age assistance, aid to dependent children, the blind, and the permanently disabled. Provides for a \$10 monthly increase from present maximum of \$55 for the aged, blind, and permanently disabled. Also raises federal contribution from present  $\frac{4}{5}$  of first \$25 and  $\frac{1}{2}$  of balance to  $\frac{4}{5}$  of first \$25 and  $\frac{5}{8}$  of balance up to the new \$65 maximum.

Federal aid to dependent children would be increased \$6 monthly from present maximum of \$30 and from present  $\frac{4}{5}$  of first \$15 and  $\frac{1}{2}$  of balance to  $\frac{4}{5}$  of first \$18 and  $\frac{5}{8}$  of balance up to \$36.

The last federal increases, made in 1952, are to end September 30. This bill has no automatic termination clause. To Finance Committee.

## New House Legislation

**HR7700—Mortgage Insurance for Medical Facilities.** (Wolverton, R—New Jersey, February 3.) Provides federal mortgage insurance of private loans for the construction of medical facilities supplying voluntary, prepayment, group practice medical care. Medical facilities include hospitals,

diagnostic or treatment centers, personal health service centers, rehabilitation facilities, and offices for physicians and dentists.

The bill supersedes HR6951. Opposed by AMA.

Mr. Wolverton feels such federal aid would result in better distribution of health facilities, stimulate private loans, extend voluntary prepayment health plans, and increase group practice.

A Medical Facilities Mortgage Insurance Fund would be created under the Surgeon General of the Public Health Service with \$2,500,000 allocated immediately and additional annual appropriations as necessary. The Surgeon General could borrow up to \$5,000,000 from the U. S. Treasury to carry out the program.

The aggregate amount of all outstanding mortgages could not exceed \$1,000,000,000 except, with the approval of the President, it could be increased another \$250,000,000.

To obtain insurance, a mortgage could not: exceed \$5,000,000; have a maturity over 40 years; bear interest in excess of 6 per cent ( $6\frac{1}{2}$  per cent in certain mortgage markets); and reserve less than 60 per cent of the insured medical facility for serving members of group practice, prepayment health plans.

The Surgeon General would set premiums not to exceed  $1\frac{1}{2}$  per cent a year of the amount of the mortgage. To Interstate and Foreign Commerce Committee.

**HR7817 — Oral Narcotic Prescriptions.** (Martin, R—Iowa, February 9.) Would permit the sale of narcotic drugs that possess little or no addiction in comparison with morphine, codeine, or cocaine on an oral prescription of a registered physician, dentist, veterinary surgeon, or other authorized practitioner.

The oral prescription must be put in writing promptly and filed with the druggist or dealer. In issuing an oral prescription, the same information as is now required on written prescriptions would be necessary.

The determination of what narcotic drugs could be prescribed orally is left to the discretion of the Secretary of the Treasury. He is to consider the views of the Public Health Service, the Food and Drug Administration, and the secretaries of national associations representing physicians, pharmacists, and narcotic drug manufacturers. The bill is supported by the National Association of Retail Druggists. To Ways and Means Committee. Supported by AMA.

**HR8079—Voluntary Social Security Extension.** (Golden, R—Kentucky, February 25.) Would extend social security coverage on a voluntary basis to professional persons. Included in this category are physicians, dentists, osteopaths, veterinarians, chiropractors, naturopaths, lawyers, optometrists, Christian Science practitioners, and others. To Ways and Means Committee.

### Legislative Notes

The House Labor Committee has ordered an investigation of racketeering in the administration of labor union welfare funds. President Eisenhower recommended such an investigation in his special labor message to Congress, saying that it was necessary to "protect and conserve" union trust funds set aside for such things as pensions and medical care. The House Ways and Means Committee has approved a proposal to exempt the first \$1,200 of annual pension payments from personal income taxes. Under present law, a worker generally is not taxed on annuities purchased by himself in his working years, but must pay tax on other types of pensions. To date the committee has taken no action on the Jenkins-Keogh proposal, indorsed by the AMA, which would permit the self employed to defer income tax payments on that portion of their earnings placed in restricted pension plans.

### AEC Reports Progress in Atomic Medicine Research

Semiannual report of Atomic Energy Commission traces progress of past six months in research achievements, postgraduate training and protection of workers' health. In 1953, 10,676 shipments of radioisotopes went from Oak Ridge to hospitals, medical schools and other institutions, greatest total since inception of program in 1946. To date, these consignments total 42,749. The "big two," which comprise nearly 70 percent of the shipments, are iodine 131 and phosphorus 32.

Other highlights from AEC report: Oak Ridge Institute of Nuclear Studies will install this spring a teletherapy unit capable of housing radiation source of several thousand curies . . . tracer studies in physiology at Brookhaven National Laboratory have immediate practical implications in control of hypertension and renal complications . . . significant findings in immunology are resulting from University of Chicago investigations of tagged amino acids.



## Griffin Hospital Appointments

Geraldine R. Huss, M.D. has been appointed full time director of the Laboratory and pathologist at Griffin Hospital and will assume her duties on July 1, 1954. Dr. Huss received her Doctor of Medicine degree at Temple University in 1949 and since then received training in pathology at Harrisburg General Hospital; Grasslands Hospital, Valhalla, New York; Greenwich Hospital and Grace-New Haven Hospital, the latter extending until June 30, 1954. She is Board eligible in anatomical and clinical pathology. Dr. Huss will receive an appointment to the faculty of the Yale School of Medicine on July 1, 1954.

Charles D'Alessio, M.D. has been appointed full time radiologist at the Griffin Hospital, Derby, after having been in private practice of radiology in Derby since 1952. Dr. D'Alessio completed the three year residency in radiology at the Hospital of St. Raphael, New Haven and is eligible for Board examinations.

Griffin Hospital announces the following staff appointments for 1954: Ralph H. Edson, M.D. president of the medical staff; Maxon M. Senfield, M.D. vice-president; John J. Narowski, M.D. secretary-treasurer; John C. Mendillo, M.D. chief of staff and chief of surgery; Arthur G. Wilkinson, M.D. assistant chief of staff and chief of obstetrics and gynecology; Theodore S. Evans, M.D. chief of medicine; William R. Wilson, M.D. chief of pediatrics; Clement C. Clarke, M.D. chief of ophthalmology; Charles Petrillo, M.D. chief of otolaryngology and rhinology; Charles D'Alessio, M.D. radiologist; Bernard Shield, D.D.S. chief of dentistry; Edward Blumenthal, M.D. acting chairman, Department of Anesthesia.

## Connecticut Hospital Association Names Executive Director

The appointment of Stuart W. Knox as executive director of The Connecticut Hospital Association, to take effect April 1, was recently announced by C. P. Goss, of Waterbury, president of The Connecticut Hospital Association. This action was taken at the March meeting of the board of trustees and was necessitated by the resignation of Hiram Sibley to accept the position as director of program development of the Yale-New Haven Medical Center.

Stuart W. Knox has served as secretary of the council on administrative practice of the Massachusetts Hospital Association and has been its account-

ing specialist since 1950. Mr. Knox, a former hospital administrator and controller, held a commission in the U. S. Army Medical Department during World War II. In addition to membership in the American Hospital Association since 1943, Mr. Knox

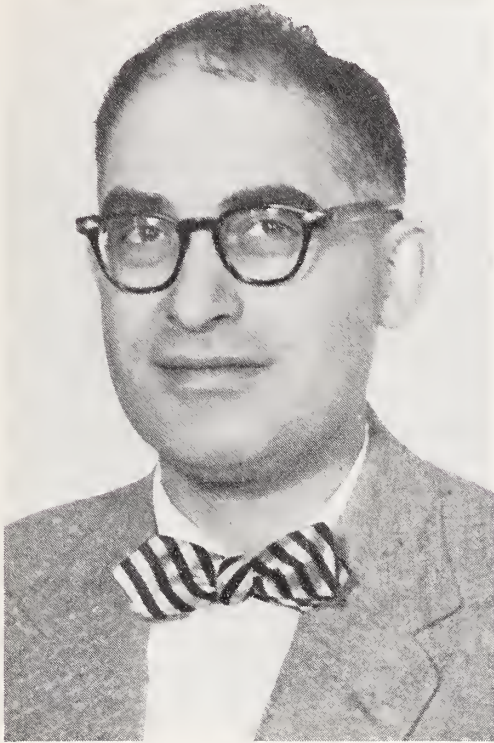


STUART W. KNOX

also holds membership in the Massachusetts Hospital Association, National Association of Cost Accountants, American Association of Hospital Accountants, and the Accountants 52 Club.

The Connecticut Hospital Association includes in its membership the 34 general hospitals of Connecticut, six hospitals which specialize in specific categories of patients, and one dispensary which cares for patients on an ambulatory basis. During the past six years the Association has pioneered in establishing a program of uniform accounting and reporting, and in establishing sound administrative practice among the Connecticut hospitals. Recognizing the need for trained personnel to provide the best possible care for hospital patients, the Association has conducted a program of educational institutes for such key hospital personnel as nurses, accountants, purchasing agents, pharmacists, dietitians, medical record librarians, housekeepers and laundry managers.

The Connecticut Hospital Association offices are located in the building owned by the Connecticut State Medical Society in New Haven.

**Samuel A. Schuyler, M.D.**

Dr. Samuel A. Schuyler, formerly chief medical officer of the Hartford Regional Office of the Veterans Administration, has been awarded a United States Public Health Service Fellowship at the Institute of Physical Medicine and Rehabilitation, New York University Medical Center.

Dr. Schuyler has been assistant chief of physical medicine and rehabilitation at the Hospital for Chronic Illness at Rocky Hill since March, 1953. He served as chief medical officer and chief of physical medicine at the regional VA office from January, 1947 until his resignation to accept the position at the Rocky Hill institution.

As a Fellow in Hospital Administration at the University of Chicago, Dr. Schuyler received an M.B.A. degree there in 1944. He served as executive physician at Sea View Hospital, Staten Island, and as deputy medical superintendent at Triboro and Queens Hospital, Jamaica, L. I., following completion of medical studies at Charing Cross Hospital Medical School, University of London, in 1939.

He plans to complete his training in physical medicine at the Institute of Physical Medicine, National Foundation for Infantile Paralysis, Warm Springs, Georgia

**Associates Honor Francis B. Woodford, M.D.**

For 27 years a general practitioner of medicine in Ridgefield, Dr. Francis B. Woodford was honored at a testimonial dinner at The Elms Inn on February 14, at which doctors, dentists and druggists in the community paid tribute to "The Country Doctor." The affair was arranged by Dr. Charles P. Izzo, dentist.

A fisherman by hobby, the doctor received an imported French-type spinner and reel, with a glass rod and lures. Mrs. Woodford received an orchid corsage.

At the table where the guest of honor and his wife were seated, the centerpiece was a miniature glass horse and buggy, inscribed to "The Country Doctor."

Two of Dr. Woodford's associates at Roosevelt Hospital in New York City, where he was an intern, were present, Dr. Nelson Sackett and Dr. White.

Many telegrams of congratulations were received.

**Student Nurse Enrollment**

Schools of professional nursing in the United States admitted 43,327 new student nurses in 1953, an increase of 1.8 per cent over 1952. Included in this group are students from 3 year diploma programs and the 4 and 5 year collegiate programs. Together these total 1,148 state approved schools of professional nursing, the majority of which are also approved for full or temporary accreditation by the National League for Nursing.

Almost one-fourth of nursing students admitted in 1953 are attending schools in the three Middle Atlantic states—New York, New Jersey, and Pennsylvania; approximately the same proportion of the students are enrolled in schools west of the Mississippi River. Although at first glance this seems to reflect an unusual concentration of schools in the eastern half of the United States, it is not too different from the distribution of the national population. Approximately 20 per cent of the population live in the Middle Atlantic area and 30 per cent west of the Mississippi. State by state analysis of admission of professional student nurses shows an increase of 785 students over the previous year with increases in 27 states and the District of Columbia, one state,



Montana remaining the same, and decreases in 20 states and the territories of Hawaii and Puerto Rico.

Throughout 1953, as a public service program of the Advertising Council, nursing has been emphasized as a career opportunity that knocks twice—for both professional and practical nursing. A recent survey of 215 schools for practical nursing made by the National League for Nursing shows that 8,543 students were admitted to schools of practical nursing during the 1952-1953 school year. These schools are either state approved or approved by the National Association for Practical Nurse Education.

Estimates indicate that between 50,000 and 60,000 professional nurses and at least 60,000 practical nurses are needed now to meet the expanding health needs of the country.

During 1952 Connecticut had 922 students admitted to the 21 state approved schools of nursing and during 1953, 959 to the same 21 schools.

### New Ambulance Group

The Connecticut Ambulance Association, Inc., a non profit corporation, was established in February of 1950 by a group of progressive ambulance operators in Connecticut for the purpose of raising the standards of ambulance service throughout the State in order to insure better service to the public.

Its sixteen members, operating private ambulance services in Bridgeport, Bristol, East Hartford, Hartford, Meriden, Milford, New Britain, New Haven, New London, Stamford, Stratford and Waterbury, conduct a training program for all new employees, use qualified drivers and attendants at all times, have adopted an insignia, and publish an annual directory of Connecticut's private ambulance services and all hospitals.

The officers of the Association are: Thomas J. Nelson of Bridgeport, president; Joseph J. Talarski of Hartford, vice-president; Joseph J. Clark of New Haven, secretary; and John F. Somers of Milford, treasurer. Directors are: Thomas J. Flanagan of New Haven, Edmund M. Campion of Waterbury, Cliff Bright of Bridgeport, Earl O'Brien of Stratford, and William J. Curtin of New London.

The Association maintains an office in New Haven. Mail should be addressed to Joseph J. Clark, secretary, P. O. Box 803, New Haven.

### Insurance Plans

*(From the AMA Public Relations Department)*

Because medical fees are the basis for much criticism of the medical profession, voluntary health insurance plans that assist the patient in paying his medical and hospital expenses greatly improve the doctor-patient relationship. Physicians can help the profession and the patient by promoting such insurance plans. It is an especially good idea to recommend these plans to patients who seem to have difficulty in meeting their medical expenses. The success of voluntary health insurance plans is the best proof that the private system of providing medical benefits is better than government control.

The physician can also aid patients in using their policies. Before a surgical procedure, for example, the doctor can discuss insurance coverage when talking about the fee for the operation. Then the patient is prepared for just how much of the cost he will have to bear. Because many persons do not understand insurance and also do not bother to read the "fine print," the physician may have to explain the policy to a patient. This often requires great tact, especially when a patient learns he has a policy that takes away in fine print the benefits outlined in large print. The physician and his office should help process insurance claims quickly and correctly. The patient identifies the insurance company with the doctor and the hospital, and, if his rightful claims are not settled to his satisfaction, he may be bitter toward all three.

In a few instances physicians have been guilty of increasing their fees so that patients could get larger amounts from insurance companies or of listing a major operation when a minor operation was actually performed. Such fraud cheats the doctor himself in the long run, for it boosts insurance premiums, makes it necessary to reduce policy benefits, and eventually dries up the source of the physician's fees. Appropriate action should be taken by mediation committees of medical societies when such frauds are discovered. Though there are inequities in insurance payments, the doctor should work through his medical society to correct them. He should promote voluntary health insurance plans and cooperate with the patient and the insurance company to the best of his ability.

FROM OUR EXCHANGES

Franklin calls our attention to the almost unrealized fact that cancer is a leading cause of death among children in the United States ("Analysis of Cancer in Infancy and Childhood," *N. Y. State Med. Jour.*, 53:14). Cancer is the fourth in the age group of one to four years and is second only to accidents in the age group of five to fourteen as a cause of death among the children of the United States. Surgery and x-ray seem to be about our only method of treatment. It is for that reason that it is important to educate mothers and nurses in the importance of looking for swelling of any type and reporting these to their physician. It is only in this way that cancer in children can be discovered early enough for effective treatment. If treated early, many cases of cancer in children are not hopeless.

\* \* \*

The following is a brief extract from an address given by Dickinson on the occasion of his assuming the presidency of the Arkansas Medical Society (*Jour. Ark. Med. Soc.*, L:1).

"I have spent my life in the practice of medicine. My father spent his life in the practice of medicine, and my boys are doing the same . . .

"I have become increasingly aware that the practice of medicine is not a static thing. It is forever changing. I am not referring to scientific changes, I am speaking of the philosophical, ethical, social and economic aspects of medicine. I feel that some of these changes have not been to the advantage of the doctor, the patient, or to the general public.

"For example, I can remember when the doctor was universally loved. My father was loved and respected much more than I am.

"I can remember when medicine was practiced to such satisfaction to the general public that they were stimulated to transcribe the following to us: 'There are men and classes of men that stand above the common herd; the soldier; the sailor; and the shepherd not infrequently; the artist rarely; rarer still the clergyman; the physician almost as a rule. He is the flower of our civilization.'

"It is an admitted fact, to us and to the general public, that we have far outstripped our predecessors in the scientific practice of medicine. We are much more successful in the curing of disease, shortening of illness and saving lives, but they do not love us and respect us as they once did.

". . . Perhaps 'we would do well to go back and pick up. This would require a critical analysis of ourselves and a reorientation'."

Obviously there are some things of value in medicine that can neither be bought nor imposed upon the doctor or the general public. We might at this point echo Dr. Dickinson's words that "it is not enough to receive this honor with humility, it should be received with a sense of obligation."

\* \* \*

Eliot, in her discussion of "Health Services and Juvenile Delinquency" (*Pub. Health Rep.*, 68:6), calls attention to the fact that "we must take every precaution we can to prevent these young people from becoming delinquent, but at the same time we must realistically face the probability that some of them will get into trouble and will need proper treatment." The encouragement of communities to do everything in their power to prevent further delinquency and to attend to the wants of those youngsters who have already become delinquent is a primary need. There should be continuing support of probation services at the local level (only half of the counties in the United States offer such a service). Dr. Eliot thinks that public and voluntary health services can make a great contribution. Mental health clinic, child guidance clinic, etc., can all make an effective contribution to the problem.

Dr. Eliot ends on a sour note to the effect that "these groups of 'problem families' in our communities offer a focal point for work not only of the health agencies but also of all our social welfare, educational, and law-enforcing agencies. Why these families have such knotty problems and why they continue to have them after great amounts of money and energy have been expended in their behalf are questions that have baffled students of our social and economic life."

\* \* \*

"Which Patients May Fly" is a modern problem; and one which confronts most physicians at one time or another. Kreinin (*G. P.*, VIII:2) is of the opinion that flying is not harmful to the vast majority of sick people. Flying is probably always contraindicated in patients suffering from severe anemia, cases of serious pulmonary disease, and patients who have developed a pneumothorax, cardiac decompensation, and coronary insufficiency. Stricture of the eusta-



chian tube predisposes to the development of ear trouble during flight and upper respiratory infections may lead to otitis media or purulent sinusitis.

Patients with mental diseases are more subject to air sickness than normal patients. It should be added that they should not fly if they have a disorder which might make them dangerous to themselves or to other passengers.

Infants tolerate air travel well and appear to be less susceptible to the early stages of oxygen lack. Infants are less susceptible to air sickness than the adult. However, once anoxia appears in an infant, the subsequent decline is rapid, and counter measures must be instituted immediately.

There is no reason why a pregnant woman should not fly up to the last month of her pregnancy.

\* \* \* \*

The treatment of chronic constipation in childhood has bothered most of us at some time or another. Commonly correction of minor physical defects, attention to the liquid intake, care of the dietary habits and, above all else, the insistence on regularity have been sufficient treatment for the correction of chronic constipation in children. However, there are a few children in which such a regime ends in failure and additional help is needed. Laxatives are indicated only after other and simpler methods have proved themselves to be insufficient and should be continued only long enough to aid the child in establishing satisfactory bowel function.

For many years prunes as a bulk laxative have produced favorable results. Burke (*Miss. Med.*, 50:5) has been experimenting with diphenylisatin, which is the active laxative principle of prunes. Isatin stimulates peristalsis, is effective in small doses and is not absorbed. Prulose Complex Liquid was the preparation used in all the cases treated for constipation. Dr. Burke reports a favorable response in every instance and that no undesirable side effects were observed. The laxative was effective in a number of cases in which response to other laxatives had been poor. Perhaps it should be added that the correction of faulty habits and of dietary indiscretions still remain a first objective in treating chronic constipation in children.

\* \* \* \*

Pulmonary "coin" lesion is for many of us an unfamiliar, descriptive term. Trimble defines the term as a lesion located in the lung substance. These lesions are round, oval or lobulated, with their edges sharply demarcated and with smooth contours, with-

out cavitation and usually without calcification (*Dis. of Chest*, XXIII:6). This group of lesions does not include masses with adjacent inflammatory reaction associated with atelectasis or those obviously arising from the chest wall or mediastinum.

In the opinion of Dr. Trimble the diagnosis of these lesions usually requires surgical exploration, for the removal of the nodule and pathological study.

The important fact about pulmonary "coin" lesions is that from 15 to 30 per cent of these lesions are malignant, and in some specially selected older age groups as high as 70 per cent of them are malignant. According to the author, pulmonary "coin" lesions should not just be watched until a clinical diagnosis can be made because by that time metastases are likely to be present and the chance for successful surgery has been greatly reduced.

Many clinicians will be inclined to doubt the authors assertion that exploratory thoracotomy "is a benign procedure comparable in risk to appendectomy and should be thought of in the same way as most physicians and even the general public have been educated to think about biopsy of a lump in the breast." Probably we all need a little more education.

\* \* \* \*

On the word of Behrend there is still much hysteria among surgeons concerning the treatment of acute cholecystitis (*Jour. of Internat. Coll. Surg.*, XIX:5). From his own experience he makes the following observations:

1. Patients with acute cholecystitis should be treated conservatively.
2. The surgeon should not become panicky and subject the patient to an emergency operation, unless it is impossible to make an exact diagnosis.
3. Starvation treatment, not mentioned by most authors, is the best method of preparation.
4. Parenteral feeding with 5 per cent dextrose, amigens and antibiotics will produce subsidence of symptoms in twelve to twenty-four hours.
5. Acute perforation is a rare occurrence. Many chronic perforations are observed at operation, but these are not under discussion.
6. Cholecystotomy, except in persons past the seventh decade of life, is not a necessary operation. The author has not performed one in many years.
7. For the occasional and inexperienced surgeon, cholecystostomy should be the chosen procedure. He should also remove the gallbladder from above downward.

# OBITUARY

Gilbert R. Hubert, M.D.

1907 - 1953



*He tao huata e taea te karo;  
He tao na aitua, ekore. (Maori)*

*"The thrust of a spear-baft may  
be parried; that of death never"*

On October 28, 1953 Dr. Gilbert R. Hubert succumbed to a rapidly progressive pathological process, the first symptom of which had appeared within the preceding month. Dr. Hubert is survived by his father, Gilbert Hubert; his wife, the former Beatrice I. Dibble of Elnora, New York; and two children, a son, Coe, age 12, and a daughter, Harriet, age 7.

Gilbert Hubert was born in Winsted, Connecticut, January 13, 1907. His early education was obtained at St. Anthony's Parochial School in Winsted and Mark Hopkins School in North Adams, Massachusetts. He was graduated from the Massachusetts School of Optometry in 1926 and received the degree of Bachelor of Arts from St. Bonaventure's College in 1930. Following his graduation from Yale Medical School in 1935, he served an internship in Long

Island Hospital. Having determined to pursue the specialty of pediatrics, he applied and obtained a three year residency in the Albany General Hospital. His training was thorough and he applied himself with zeal and enthusiasm. During this period his contributions to scientific literature were prolific. His particular interest lay in the field of endocrinology, as is shown by this random selection of titles of articles of which he was coauthor: "Effect of Synthetic Male Hormone Substance on Descent of the Testicle in Cryptorchid Boys," "Photographic Nature of Tanning of the Human Skin as Shown by Studies of Male Hormone Therapy," "Mental and Behavioral Changes Following Male Hormone Treatment of Adult, Castration, Hypogonadism and Psychic Impotence," and "Differential Diagnosis of Pseudocryptorchidism and True Cryptorchidism.

In 1940 Dr. Hubert returned to his home in Torrington, Connecticut and entered the private practice of pediatrics. He immediately identified himself with the department of pediatrics in Yale Medical School and served as clinical instructor for two years. World War II brought a sudden interruption. Following his own sense of duty and loyalty, he accepted a commission in the United States Navy in September 1943. After serving overseas in the European theater for a period of two years, he was finally separated from the service as a lieutenant commander in March 1946. Throughout his professional career here he was a member of the medical staff of the Charlotte Hungerford Hospital. During the interval from 1941 forward he served as chief health officer for the Torrington schools. He was a member of the Litchfield County Medical Association, and at the time of his death was president of the Torrington Medical Society.

Attempt to eulogize the attributes of Gilbert Hubert would be presumptuous. By words one cannot add or detract from his exemplary pattern of behavior. His life and actions were motivated by deep, sincere and unwavering religious conviction. Especially in an age of rampant materialism, such profound faith and devotion as he possessed is rare and beautiful. It was natural to find in him a highly



developed sense of justice and charity. The principles he possessed were based upon fundamental Christian ethics and were obviously not subject to compromise or expediency. Idealism and unselfish devotion were manifest in his love and loyalty toward family and home. He jealously conserved and guarded every second of time not occupied by professional pursuits in order to share these moments with his wife and children. In younger years he had developed a high degree of skill in golf. Despite his keen interest and desire to continue participation in this sport, he played only a few times after the war because he felt that he "wanted to be with his family." In retrospect it would almost seem that he had been given prescience or precognition of the brevity of the life span remaining for him to enjoy. A total selfless attitude of kindness and service characterized his relation with his patients.

His hobbies were limited. He found much satisfaction in the study of religion and religious philosophy and filled his library with a number of books pertaining to these subjects. He enjoyed membership in the Serra Club, the Holy Family Retreat League, and was adult advisor to the C.Y.O. The diversion of greatest joy, however, was his camp on a lake near Edinburgh, New York in the foothills of the Adirondack Mountains. Here, with his family, he felt closest to his Creator and found equanimity. What a lasting satisfaction to his wife and children to have had almost two whole months together there just a few months before his death!

Francis A. Sutherland, M.D.

### Committee on Foods, Drugs, Cosmetics and Devices

Represented at the meeting of this committee held in New Haven December 3, 1953 were the following member societies and institutions: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William H. Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Mr. Felix Blanc, representing the Pharmacy Commission; Dr. Barnett

Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission; Dr. Edward T. Wakeman, pediatrician, by invitation as consultant.

#### BORIC ACID DUSTING POWDERS

The safety of boric acid dusting powders was discussed and it was voted that the Committee exonerate dusting powders containing 5 to 10 per cent of boric acid until further evidence was brought forward by the U. S. Food and Drug Administration.

(The following press release, dated January 30, was received by Dr. Fisher on February 2:

"The Food and Drug Administration, Department of Health, Education, and Welfare, has investigated the use of talcum powders prepared with 5 per cent boric acid powder and finds there is no hazard in the use of these products, according to a statement released today.

"Borated talcum powders with 5 per cent boric acid have been in use for many years as dusting powders for babies.

"Clinical, animal, and chemical research investigations as well as consultation with leading medical authorities who have conducted research in the field of baby talcs confirm their safety, according to the Food and Drug Administration.")

#### ANTI ENZYMES IN DENTRIFICES

Several sample advertisements were displayed and lay magazine articles on the use of anti enzymes in tooth pastes were discussed by the committee. The committee went on record as branding claims for the prevention of tooth decay by these anti enzyme preparations as misleading if not false. A conservative attitude has been urged by the Council on Dental Therapeutics and the Council on Dental Research of the American Dental Association.

#### A NEW INSULIN

Dr. Greenhouse remarked that a new type of insulin (Insulin Lente Type 70/30) had recently been offered for clinical investigation. This insulin, containing 0.02 mgm. of zinc per 100 units, contained an acetate buffer and was slowly soluble at the pH of the blood; no foreign protein was present. Preliminary clinical results indicated that it was an intermediate-acting insulin—it had a slightly longer action in some patients.

## LETTERS TO THE EDITOR

### Reporting of Prodromic Dreams Requested

To the Editor:

I am making a special study of what were termed, more than a century ago, prodromic dreams. These are recurring dreams in which the dreamer is troubled by dream images pointing, directly or symbolically, to ill health in some region or organ of the body.

Such dreams may, if the hint is heeded, lead to x-ray or other medical examination revealing disease curable by prompt treatment, perhaps incurable if prompt treatment is not given.

A typical prodromic dream is one in which the recurring dream image is of mice gnawing at some part of the body, later found to be the seat of a malignant or non malignant growth. Most laymen are unaware of the possible diagnostic value of such dreams. As I feel the publication of the results of my study might be helpful to many, I now wish to include examples from the experience of practising physicians and surgeons.

Hence I would greatly appreciate receiving from readers of this letter reports of prodromic dreams encountered in the course of their clinical practice. My address is 35 Vernon Street, Hartford 6, Connecticut.

H. Addington Bruce,  
Fellow, American Academy of  
Arts and Sciences

### What is Specialization?

February 24, 1954

To the Editor:

The President's Page in the February CONNECTICUT STATE MEDICAL JOURNAL was of interest to me, and I should like to comment on it.

My thoughts on the subject, I am sure, are quite similar to yours, but I wonder exactly what the word "Specialization" means to even the doctors—much less the public.

It seems to me that what we fail to bring out many times in our discussions of specialization in contrast to general practice is the fact that there are several different categories of specializations.

What is usually meant by specialist is the term as applied to the specialist who deals with one area of the body or one system of the body.

However, there is another type of specialization which is perhaps more general in nature. It is an Age Group Specialization and includes the fields of pediatrics and internal medicine. Where these types of specialization fit into your article I am not quite clear.

There is, in my opinion, a lot more to medicine than diagnosing and treating illness—namely, preventing organic and functional illness. It has not been proven to me as yet that General Practitioners do as good a job in this field of prophylactic medicine as the pediatrician or internist. Maybe he hasn't the training; maybe he hasn't the time; some of them don't have the interest as far as children are concerned anyway.

Therefore, I wonder if it is wise to imply that pediatricians are needed to give adequate medical care to only fifteen per cent of the children.

What is adequate pediatric care—or adequate medical care in general for that matter? Some of my medical friends tell me that more rheumatic fever is being seen in the twenty-thirty age group and less in the childhood years. Does this mean perhaps that more people are being cared for by pediatricians (who have the reputation of using antibiotics more freely than those who treat adults) and then stop their regular check-ups after they get out of that age group?

It is the feeling of some of us that adequate pediatric care should include:

1. Emergency care of acute illness or accidents. In my opinion the well trained general practitioner will do an adequate job with this.
2. Care of unusual acute or chronic diseases of children. Here even the most rabid antispecialists are glad to have a pediatrician available occasionally.
3. Routine check-ups at the doctors office.
4. The maintenance of adequate immunizations including tetanus toxoid.
5. Adequate prophylactic and therapeutic care of the many functional problems that constantly come to the attention of the pediatrician. Just think of the time the pediatrician spends on this one.

I won't argue at all with the idea that the general practitioner is the backbone of American medicine, but I certainly feel that more than fifteen per cent of the children should have the advantage of care by pediatricians, at least until general practice fulfills adequate pediatric care as outlined above, in which event the consummation devotedly to be desired will have been gloriously achieved.

Sincerely,

James H. Root, Jr., M.D., F.A.A.P.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. Dewey Katz, Hartford  
*President-Elect*, Mrs. Newell W. Giles, Darien  
*Second Vice-President*, Mrs. Winfield Kelly, Norwich

*Recording Secretary*, Mrs. Walter Nelson, Cromwell  
*Corresponding Secretary*, Mrs. Stevens J. Martin, Hartford  
*Treasurer*, Mrs. Norman J. Barker, Collinsville

### Annual Meeting

Dr. John Blasko, the new State mental health commissioner, will speak at the Annual Meeting of the State Auxiliary on April 28. This will be his first speaking engagement in the State. We feel this is fitting in view of the fact that it was a Connecticut State Medical Society legislative measure that brought about the creation of his post, and that the Auxiliary played an important role in putting this legislation through the last Connecticut Assembly.

The luncheon will be held at Trinity College in Hamlin Dining Hall following a business meeting in the Library Conference Room. Reservations at \$1.80 must be sent to Mrs. Asher Baker, 48 Bartlett Street, Portland by April 24. Dr. Albert C. Jacobs, president of the College, will address the members at the opening of the meeting and welcome them to Trinity College campus.

### Connecticut Nutrition Council

We have some interesting figures on the Connecticut Nutrition Council meeting in February. Representation of teachers was as follows: 26 per cent elementary school personnel; 14 per cent home-making teachers; 12 per cent home economists from college and university extension classes. Those concerned with School Child Health were represented by 26 per cent elementary school personnel; 13 per cent school lunch personnel; 14 per cent home making teachers; 12 per cent school nurses and town health personnel.

The meeting aroused interest in school nutrition instruction. It gave positive help for classroom experiences. It made available pertinent materials; gave new facts; revised basic facts and showed many useful, promising practises.

Mr. James Burch set up the *Today's Health* exhibit for the Auxiliary and was present throughout the meeting. The Auxiliary was represented by

Mesdames Morton Arnold, Creighton Barker, William Horton, Dewey Katz, Arthur D. March, William S. Maurer and F. Erwin Tracy.

### Art-Musicale

On Sunday, March 28 the Physicians' Art-Musicale was held at the Avery Memorial with a fascinating Picasso exhibit as background. A lavish buffet supper following the cocktail hour was served in Tapestry Hall. The musical program was presented by Marynka Crosby, pianist; Dr. Jack Segal, violinist accompanied by Mrs. Crosby; Mrs. Louis Spektor, soprano; Mrs. Sidney Sewall, pianist; Dr. R. R. Berneike, clarinetist accompanied by his wife; Drs. A. Deming, James Johnson, F. W. McCarthy, Jr., and John Wells, quartet.

### Recommended Reading

A tribute to the doctor's skill is the essence of *Fortune's* article in the February issue entitled "The M.D.'s Are Off Their Pedestal."

### Fairfield County

The need for registered medical record librarians has been brought to the attention of the Auxiliary. As there have been so few applicants for nursing school scholarships, this money will be made available to any girl in the County who desires to enter the library field.

A \$350 contribution was given the AMEF.

Gifts to Laurel Heights during the Auxiliary working year include 12 card tables, 30 bed boards for writing, etc., book and magazine subscriptions, articles for Bingo prizes, Chinese checkers and marbles, gifts to patients who remained in the hospital over the Christmas holidays.

A nonprofit membership tea will be held this spring to welcome new members.





AUXILIARY AT NUTRITION COUNCIL EXHIBIT

### Litchfield County

The annual meeting was held on March 19 at the home of Mrs. Gerald Mitchell in Goshen. Mrs. Jeannette W. Shinn, district secretary of the Children's Services of Connecticut, spoke. Members were asked to bring articles of clothing, toys and knick-knacks for the Thrift Shop in Torrington which is operated as part of the work of the Children's Services.

A dance to raise funds for the AMEF will be held at Torrington Country Club on April 24.

### Middlesex County

The annual meeting will be held on April 15 at Oakdale Tavern, Wallingford. Professor Wilbur Snow, former State Governor and retired head of

Wesleyan University's English Department, will read selections from his own poems.

### New London

During February the Auxiliary ran two successful social events. Fifty couples attended the dinner dance at Lighthouse Inn on February 10. On the 23rd there was a membership tea at the home of Mrs. Joseph Woodward in New London. Mrs. Winfield Kelly and Mrs. Julian Ely presented a musical performance. In addition there was an exhibit of paintings, painted trays and furniture done by members.

The annual meeting took place at Lighthouse Inn on April 6. Dr. James V. MacGregor of Uncas-on-Thames, formerly of London, spoke on "Socialized Medicine in Britain Today."



## SPECIAL NOTICES

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

April 1

Some Newer Aspects of Male Endocrinology  
Marvin Grody, M.D.

April 8

Bronchial Asthma  
George Hurwitz, M.D.

April 15

The Discussion of Bilateral Osteo-ectomy  
Victor H. Rubino, D.D.S.

April 22

Clinicopathological Conference  
Paul M. Sherwood, M.D.

April 29

Facets of Liver Function Tests  
Chester W. Fairlie, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut (Main Conference Room).

### HARTFORD HOSPITAL

Saturday Morning, 11 o'clock, Guest Speakers  
April 3 to June 5, 1954

April 3

John McK. Mitchell, M.D., dean, University of Pennsylvania, School of Medicine  
Medical Education at the Mid-Century

April 10

Carl Javert, M.D., associate professor of obstetrics and gynecology, Cornell University College of Medicine  
10 A. M. Pathology of Endometriosis  
11 A. M. Treatment of Threatened Abortion

April 17

Joseph E. Sokal, M.D., assistant professor of medicine, Markle Scholar, Yale University School of Medicine  
How Dangerous Are Thyroid Nodules?

April 24

John R. Paine, M.D., professor of surgery, University of Buffalo School of Medicine  
The Overlooked Common Duct Stone

May 1

S. J. Thannhauser, M.D., emeritus professor of medicine, Tufts College Medical School  
Case presentations

May 4, Tuesday, 12 noon

Charles F. Code, M.D., Mayo Clinic, Rochester, Minnesota

Gastrointestinal Motility Studies in Human Beings

May 8

Leland S. McKittrick, M.D., clinical professor of surgery, Harvard Medical School  
The Treacherous Colon

May 15

John R. Paul, M.D., professor of preventive medicine, Yale University School of Medicine  
Immunization Against Poliomyelitis; Dwight Griswold Memorial Lecture

May 22

Joseph Hayman, M.D., dean, Tufts College Medical School  
Physiology of Chronic Kidney Disease

May 29

Mario Stefanini, M.D., Department of Hematology, New England Center Hospital  
Dynamic Aspects of the Hemostatic Mechanisms and Their Impact on the Diagnosis and Treatment of Hemorrhagic Syndromes

June 5

Philip D. Wilson, M.D., surgeon-in-chief, Hospital for Special Surgery, New York City; clinical professor of orthopedic surgery, Cornell University College of Medicine  
Stress Reactions Following Operations on Bones and Joints

### ASSOCIATION OF CONNECTICUT TUMOR CLINICS

The spring meeting of the Association of Connecticut Tumor Clinics will be held at the New Britain General Hospital on Thursday, April 15, 1954 at 4 P. M.

The guest speakers will be Dr. Harold W. Jacox, professor of radiology, College of Physicians and Surgeons, Columbia University; chief, Radiation Therapy Division Radiologic Service, Presbyterian Hospital, New York City; and Dr. Jerome Urban, attending surgeon, Breast Service, Memorial Hospital and assistant clinical professor of surgery, New York Hospital.

Dr. Jacox will talk on "General Aspects of Radiation Therapy" and Dr. Urban will discuss several aspects of the treatment of breast cancer.

This will be an outstanding program and should be of interest to a large section of the medical profession.



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## MIDDLESEX MEMORIAL HOSPITAL

The Middlesex Memorial Hospital at Middletown has had, for the last few years, an association with the Yale Medical School, whereby the training program for interns is under the direction of the medical school. At present Dr. Robert Gordon is in direct charge of the program and from time to time he arranges for faculty members of the medical school to conduct rounds and give lectures. The following is the detailed schedule for the current educational program:

### Monday

10 A. M. Ward Rounds

Noon—Clinical Pathological Conference alternating with Medical Chest Conference

3 P. M. X-ray Conference

### Tuesday

9 A. M. Middlefield School Health Program, intern on pediatrics

9 A. M. Ward Rounds on tuberculosis, Connecticut State Hospital

9 A. M. Cardiac Clinic, second and fourth week of month  
Noon—Electrocardiography

2 P. M. Urology Conference

9 P. M. Journal Club, first and third week of month

### Wednesday

9:30 A. M. Tumor clinic, first week of month

9:30 A. M. Psychosomatic Rounds, last two weeks of month

11 A. M. Ward Rounds

Noon—Medical Motion Pictures, first and second week of month

Noon—Lectures in Clinical Neurology

1:30 P. M. Prenatal clinic, first and third week of month

### Friday

10 A. M. Ward Rounds

Noon—Grand Rounds

In addition to the daily ward rounds conducted by the senior man on service in each branch, there are frequent seminars on problems in surgical diagnosis and management and in clinical gynecology and gynecologic pathology.

## LECTURES ON AGING PROBLEMS

Martin Gumpert, M.D., of New York City, an internationally known specialist in problems of older persons, will deliver a series of lectures on "Problems of Aging" at the Kessler Institute. The lectures will be given on six consecutive Thursdays beginning on Thursday, April 15, from 7:30 P. M. to 9:00 P. M.

The lectures are open to the public and are designed primarily for a lay audience, although professional workers will also find much to interest them in the series. Admission to the six lectures is five dollars; single lectures may be attended at a cost of one dollar per lecture. Persons desiring to enroll should communicate with Miss Joyce M. Collins, registrar, at the Kessler Institute for Rehabilitation, West Orange, New Jersey.

During the opening lecture on April 15, Dr. Gumpert

will discuss "What is Aging?" "Normal Old Age" will be the topic of the lecture on April 22, and on April 29 the topic to be discussed will be "Social Problems of Aging." Two lectures on "Medical Problems of Aging" will be presented on May 6 and May 13. The concluding lecture on "Old Age Has a Future" will be delivered on May 20.

Among the topics to be considered at the various lectures are health problems of the older person, family and community relations, social facilities for the older person, and future plans of and for the older person. Dr. Gumpert will cover the diseases peculiar to old age in the two lectures on "Medical Problems of Aging."

Dr. Gumpert is the author of numerous books, including *You Are Younger Than You Think*, published in 1944. He is a member of the American Geriatrics Society and the Gerontological Society.

## MASSACHUSETTS ASSOCIATION OF MEDICAL TECHNOLOGISTS

The Massachusetts Association of Medical Technologists will hold its annual meeting April 24, at Hotel Somerset, Boston. In addition to the business meeting the following scientific program is planned. Dr. John Conlin of the Massachusetts Medical Association will speak on the "Future of Medical Technology in Massachusetts." Dr. Wendell Caraway of the Rhode Island Hospital will speak on "Protein Bound Iodine," and Dr. Arnold Lear will speak on "Current Concepts Concerning the Anemias." All workers in the field are welcome.

## CEREBRAL PALSY PROGRAM AT NEWINGTON HOME

Dr. Meyer Perlstein of Chicago, nationally known authority in cerebral palsy and neurological diseases of children, will present an all day program dealing with cerebral palsy at The Newington Home and Hospital for Crippled Children, 9:00 A. M. to 5:00 P. M., Tuesday, April 27, 1954. Dr. Perlstein will review the work being done on the cerebral palsy service at The Newington Home and Hospital, presenting a series of case demonstrations and short clinical discussions. The program is under the joint sponsorship of The Newington Home and Hospital for Crippled Children, The Connecticut Society for Crippled Children and Adults, Connecticut State Department of Health, Division of Crippled Children and the University of Connecticut School of Physical Therapy. Members of the medical profession are cordially invited to attend this program.

## SILLIMAN LECTURES 1954

Professor Ragnar Granit, director of the Medicinska Nobelinstitutet, Neurofysiologiska Avdelningen, at Stockholm, is to give the Silliman Lectures for 1954 at Yale University, at 4:30 P. M., on April 29 and 30 and May 3, 4, 5, 6, and 7, under the general title, *Receptors and Sensory Perception*. The titles of individual lectures are to be as follows:

1. Historical background. The electrophysiological approach to primary processes.

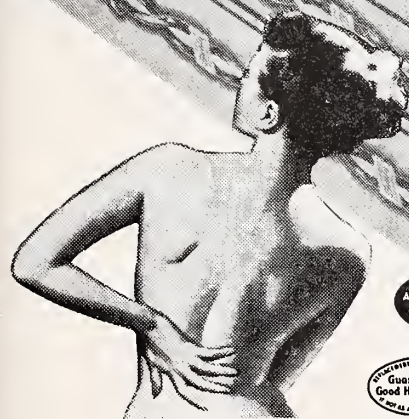


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2. Principles of organization in skin organs and retina. Fibre size. Receptive fields. Receptors re-represented in the brain.
3. Spontaneous activity in sense organs and its functional significance.
4. Present state of dominator-modulator theory. Photochemical correlations.
5. The electroretinogram. (This chapter will not be included in the Lectures.)
6. Muscle receptors and their reflex action.
7. Spinal and supraspinal control of posture and movement by the x-loop to muscle receptors.
8. Sensory discrimination and integration.

The Lectures will be open to all those interested in neurophysiology, psychology, psychiatry, and related fields. This Silliman series will mark the fiftieth anniversary of those on the integrative action of the nervous system given in the spring of 1904 by Sir Charles Sherrington.

### EASTERN STATES HEALTH EDUCATION CONFERENCE 1954

The 1954 Eastern States Health Education Conference of The New York Academy of Medicine will be held at The New York Academy of Medicine, 2 East 103 Street, New York City, on Thursday and Friday, April 29 and 30, 1954. The programme will include four sessions and an evening dinner meeting. The dinner meeting will be on Thursday evening.

The subject of this year's Conference will be Communication in Health Education.

Health education involves three major factors: namely, (a) Goals or objectives; (b) motivation; (c) communication; and while full consideration must be given to each of these components, and while no one component is more important than the other—"where there is no communication, there is less than nothing."

Communication is not primarily a psychological problem. It is not an issue of semantics. Although excessive complexity in thought or language can and may impede communication, it is not the major impediment to communication. Basic English is not a sovereign remedy for communication difficulties.

Communication is primarily a matter of interpersonal relations, best achieved when the communicant appreciates the reference framework, or the gestalt in which the other person operates. This reference framework has many co-ordinates, such as ethnic, economic, social, religious, and cultural. It includes distinctive anxieties, resentments, ambitions, value assessments, beliefs, aesthetic tastes, and prestige personalities.

Among the contributors to the Eastern States Health Education Conference are Professors William McPhee and Elihu Katz of Columbia University's Bureau of Applied Social Research, Dean Louis Hacker of the School of General Studies at Columbia University, Dr. Leo Lowenthal of the U. S. State Department's Voice of America, Dr. Shirley A.

Star of the National Opinion Research Center at the University of Chicago, and Prof. Earl Lomon Koos of the School of Social Welfare at Florida State University.

A workshop session will be held as part of the Eastern States Health Education Conference, and the concepts of Communication will be applied to and tested in current health education materials and procedures.

Participation in the Conference is limited. Those interested in the Conference should address themselves to Iago Gladston, M.D., The New York Academy of Medicine, 2 East 103 Street, New York 29, N. Y.

### WATERBURY HOSPITAL WATERBURY HEART ASSOCIATION

Present a Heart Symposium at the Waterbury Hospital  
Thursday, May 6, 1954—11:30 A. M. to 1:30 P. M.

#### I—"Some New Concepts of Hypertension"

George A. Perara, M.D., assistant professor of medicine, Department of Medicine, College of Physicians and Surgeons, Columbia University

#### II—"Pathological Aspects of Hypertension"

Levin L. Waters, M.D., associate professor of pathology, Yale University School of Medicine

#### III—"The Use of Hypo-Tensor Drugs"

Edward D. Freis, M.D., Department of Medicine, Georgetown University Medical School, Washington, D. C.

### CONNECTICUT TRUDEAU SOCIETY

The regular Spring Meeting of the Connecticut Trudeau Society will be held at Cedarcrest, Newington, on Wednesday, May 26, 1954, at 8:00 P. M.

Dr. Maurice B. Strauss, chief, Medical Service, Veterans Administration Hospital, Boston, Massachusetts, will discuss "Metabolism and Fluid Balance as it Effects the Thoracic Surgeon, the Cardiologist, and the Internist."

Members and interested physicians are cordially invited to attend.

### THIRD INTERNATIONAL POLIOMYELITIS CONFERENCE

Rome, Italy, September 6-10, 1954

The Conference will include five scientific sessions, official delegate reports, scientific exhibits, scientific, educational and technical exhibits, demonstrations of approved apparatus, and film demonstrations. Headquarters will be at the Orthopedic Clinic of the University of Rome.

Correspondence should be addressed to Secretariate of the Third International Poliomyelitis Conference, Via Lucullo 6, Rome.

John R. Paul of New Haven is chairman of the Scientific Program Committee and will address the last session of the Conference on "Future Prospects."





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**Kent** with the exclusive Micronite Filter



## NEWS

*from County Associations*

## Fairfield

At the Annual Convention of the American Academy of Orthopedic Surgeons held in Chicago in January, Philip L. Staub of Bridgeport was elected a Fellow in the American Academy of Orthopedic Surgeons.

Benjamin Spector, professor of anatomy and professor of history of medicine at Tufts College Medical School and consultant to the New England Center Hospital, was the speaker at the March 2 meeting of the Bridgeport Medical Association held in the Nurse's Auditorium at St. Vincent's Hospital in Bridgeport.

Albert Levenson, secretary of the Bridgeport Medical Association, spent the month of March in Florida.

The Bridgeport Chapter of the Connecticut Academy of General Practice in association with the Division of General Practice of Bridgeport Hospital is sponsoring a lecture series on "Office Gynecology" to be given by Dr. C. Donald Kuntze, associate professor of obstetrics and gynecology at New York Medical College. The lectures will be given at Bridgeport Hospital on the second and fourth Fridays at 8:30 P. M. during the months of April and May. A similar series of lectures on "Industrial Medicine" is planned by the group for the fall months.

The semi-annual meeting of the New England Proctologic Society will be held at the Elton Hotel in Waterbury on Saturday, May 8. Joseph Burke will be the host. Harry E. Bacon, professor of proctology at Temple University Medical School in Philadelphia, will be the guest speaker. The title of Dr. Bacon's paper will be, "Adenomatous Polyps of the Colon and their Surgical Management." J. Grady Booe, proctologist at Bridgeport Hospital, Bridgeport, president of the society, will preside.

William Kaufman of Bridgeport is the author of "Some Psychosomatic Aspects of Food Allergy" published in *Psychosomatic Medicine*, issue of January-February, 1954.

## Hartford

Alfred L. Burgdorf, City of Hartford health director, notified HCMA last month that the City of Hartford is recommending discontinuance of Isolation Hospital facilities at McCook Memorial to pay cases in Hartford and all cases from surrounding towns about July 1, 1954.

WKNB-TV recently programmed an HCMA sponsored TV film called, "Your Doctor." Made under the auspices of the AMA, it depicts the powerful role the family physician plays. You saw it if you attended HCMA's 1952 semi-annual meeting in Bristol.

In process is a card reminding you to designate number of refills on prescriptions. The Pharmaceutical Society, which is collaborating on the card, will deliver them to your office very soon.

Officers for 1954 of the Manchester Memorial Hospital staff are: Dr. Elmer A. Diskan, president; Dr. Jacob A. Segal, vice-president; and Dr. Joseph C. Barry, secretary.

Dr. Dewey Katz' article on "Salzman's Nodular Corneal Dystrophy" was recently published in *Acta Ophthalmologica* of Copenhagen, Denmark.

New staff appointments at the Hartford Hospital are: Visiting Staff—Burdette J. Buck in medicine; Louis F. Middlebrook in obstetrics; and John C. Allen in physical medicine. Associate Staff—Drs. Ranold J. M. Steven in anesthesiology, W. Holbrook Lowell in medicine, and Loftus L. Walton in obstetrics-gynecology. Assistant Staff—John B. Wells in medicine, Forrest D. Gibson, Robert W. Shreve, James M. Bunce in obstetrics-gynecology, Leon W. Zimmerman in ophthalmology, Roger W. Davis in orthopedics, Ludwig J. Pyrtek, Donald R. Morrison, John F. Reed and Irving Waltman in surgery.

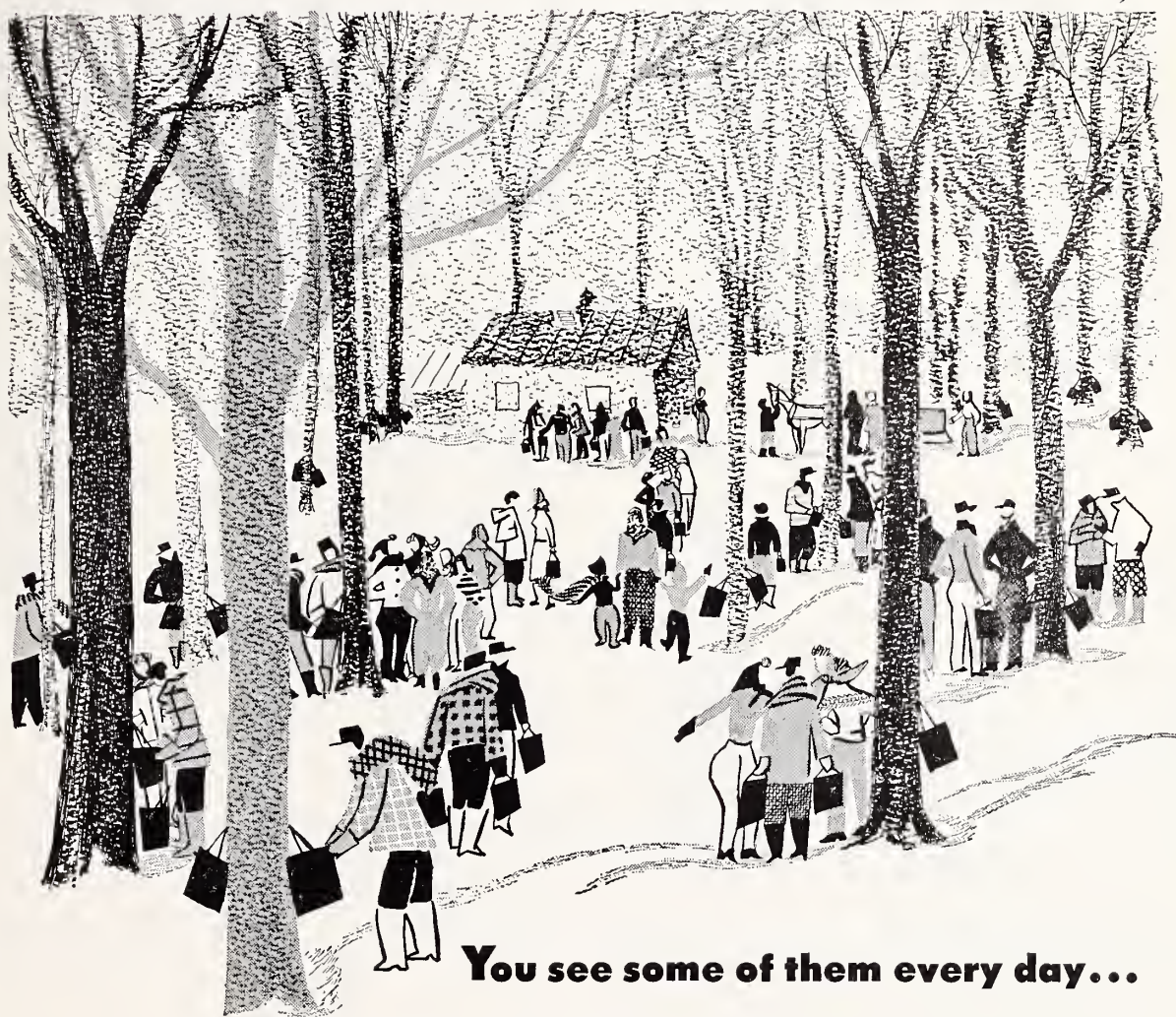
The Hartford Seminary Foundation has announced the appointment of Dr. Charles V. Goff as visiting professor of physical anthropology.

Dr. Louis Spekter has been named director of the Bureau of Maternal and Child Hygiene for the State.

During 1953 the HCMA Board of Directors met 8 times, for a total of 32¼ hours. Attendance at these meetings averaged 20 physicians per meeting. Total time spent at these meetings by all attending was 645 hours.

Celebrating their 50th anniversary as members of HCMA this year are Drs. Orin R. Witter of West

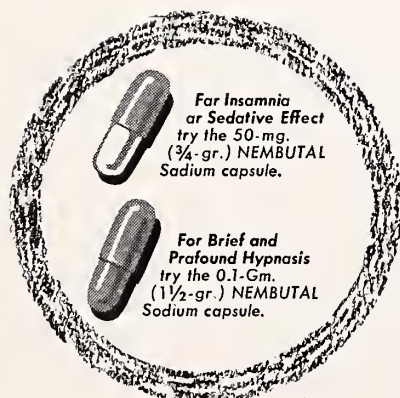




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Jack Gurwitz is the author of "The Location of Lymphatic Injury By the Use of Sky-Blue Dye" published in *New England Journal of Medicine*, February 11, 1954.

## Middlesex

The annual meeting of the Central Medical Association was held at the Commodore Macdonough Inn on Thursday, February 11. The following men were elected to office for the coming year: Julius Grower, president; Aldo Santiccioli, vice-president; John Korab, secretary; Sanford Harvey, treasurer.

The speaker of the evening was Paul Rosahn, pathologist at New Britain General Hospital, who told of his year's stay in Thailand as part of a medical education team. The talk included a description of the country and its people, their economic and political problems. It was interesting and thought provoking.

## New London

The monthly dinner lecture meeting of the Lawrence and Memorial Associated Hospitals was held Thursday, February 18. The speaker was Burdick G. Clarke, instructor in urology, Tufts College Medical School and associate in urology at the New England Center Hospital. His subject was "Office

Urology." These meetings have been well attended. Malcolm Ellison has lined up a fine program for the coming year.

The New London Chapter of the Connecticut Heart Association had its monthly cardiovascular lecture on Thursday, February 25 at the Lawrence and Memorial Hospitals, New London. Guest speaker was Benedict Massel from the Good Samaritan Hospital, Boston. His subject was "Prophylaxis Treatment of Rheumatic Fever."

The regular monthly meeting of the staff of the William Backus Hospital was held on Thursday, February 11. Stephen D. Fleck, associate professor of psychiatry, Yale Medical School, spoke on "Psychiatric Services in the Community." The meeting was preceded by a dinner.

William A. Kramm, M.D. announces the opening of his office for the general practice of medicine and surgery at Hope Street, Niantic.

The Woman's Auxiliary had their annual dinner dance at the Lighthouse Inn on February 10. It was well attended and the reports are that everyone seemed to enjoy themselves.

Regular monthly meeting of the New London County Medical Association was held Thursday, March 4 at the Uncas-on-Thames Sanatorium. The speaker was Louis Weinstein, attending physician at the Haynes Memorial Hospital of Infectious Diseases, Boston. His topic was "Uses and Abuses of Antibiotics." A dinner at Longo's Inn preceded.

The regular monthly meeting of the staff of the William W. Backus Hospital was held on Thursday, March 11. The speaker was Joacob Lerman and the subject, "Problems in Endocrinology." A dinner preceded the meeting.

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## Notice on Hearing on Regional Medical School

Robert H. Alcorn, Chairman of the Legislative Commission on the Regional Medical Dental and Veterinary School, wishes to announce that the Commission will hold a public hearing in the hall of the House of Representatives, State Capitol, commencing at 10:30 in the morning on April 28, 1954. Physicians interested in this question are invited to attend and present their views.

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## NEW BOOKS IN REVIEW

**DOCTOR—IT TICKLES!** By Henry Gregor Felsen. New York: Prentice-Hall, Inc. 1953. 120 pp. \$2.95.

Reviewed by STANLEY B. WELD

A bit corny but good for a few laughs. The real satire is expressed in the chapter, "Magazine Medicine Makes Doctors Obsolete." This should be a multi vitamin for public consumption.

**THE YEAR BOOK OF DRUG THERAPY.** Edited by Harry Beekman, M.D. Chicago: The Year Book Publishers, Inc. 1954. \$6.

Reviewed by DONALD S. HAUSS

This volume contains abstractions of what the author considers to be the most important journal articles gleaned from the world literature on drugs and drug therapy in the period August, 1952 to August, 1953. The articles have been hand picked and evaluated by the author and are appended with his own personal editorial comments. Included are articles concerned with every field of medicine and the specialties. The major sections deal with the Antibiotics, Cardiovascular Diseases, and Internal Medicine, and there are briefer sections on Allergy, Dermatology, Hematology and Endocrinology, as well as Neuropsychiatry, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Pediatrics and Surgery.

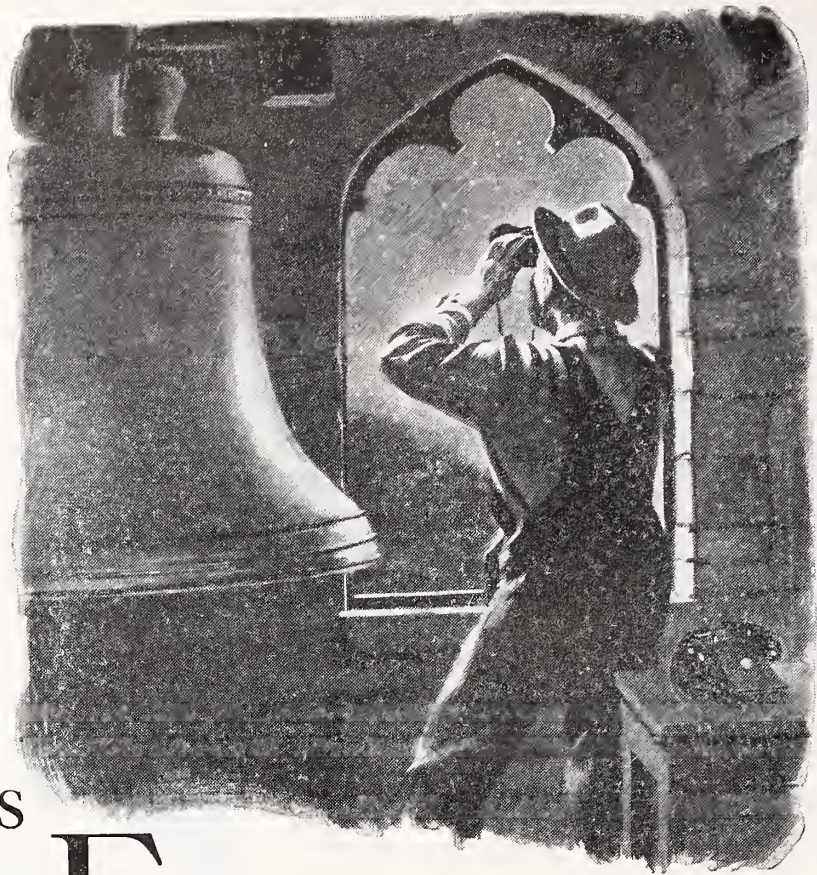
The section on Antibiotics not only deals with the use of the newer antibiotics but also contains many articles pertaining to the indiscriminate use of these drugs.

The Cardiovascular literature contains summaries covering the therapy of arrhythmias, the treatment of refractory congestive heart failure as well as extensive coverage of the newer therapeutic agents used in the medical management of hypertension.

Included in the Internal Medicine subdivision are numerous articles on the therapy of tuberculosis, the newer concepts of therapy in parasitic infestations and the evolution of several chemotherapeutic agents used in the therapy of neoplastic disease. There are many intriguing summaries on the drug therapy of peptic ulcer, ulcerative colitis and liver diseases. There are also extensive summaries dealing with the experimental trials of ACTH and Cortisone in varying disease entities, which should prove of interest to all readers.

The articles chosen in all sections describe the newest drugs, stating how they are best used and stress the essential facts to be kept in mind concerning pharmacology, mode of action, dosages, indications, contraindications, toxic and side effects. The book is very well indexed, fairly well organized and quite objective and unbiased as far as the author's comments are concerned. Each of the summaries in the volume is referenced by footnotes, so that the original article can be found where desired quite readily. This volume should prove of value to any physician, general practitioner or specialist who wishes to keep up with the latest in drug therapy with a minimum of effort. It is highly recommended.





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## H. M. MARVIN, M. D.

Born Jacksonville, Florida

A.B., Davidson College

M.D., Harvard Medical School

Sc.D. (Hon.), Davidson College

Intern, Peter Bent Brigham Hospital, Boston

Director of medical relief work in Alexandropol, Russian Armenia

Resident, Massachusetts General Hospital

Instructor in Medicine, Assistant Professor, Assistant Clinical Professor, and  
(since 1933) Associate Clinical Professor of Medicine, Yale University  
School of Medicine

Guggenheim Memorial Fellowship, 1926

Attending Physician, Grace-New Haven Community Hospital

Consulting Cardiologist to several Connecticut hospitals

Member of original group certified by American Board of Internal Medicine  
as specialist in cardiovascular disease

Member of Board of Directors and Executive Committee, 1928—, formerly  
Chairman of Executive Committee and Executive Secretary, President-  
Elect, 1948-1949, and President of American Heart Association, 1949-  
1950

Member of Editorial Board of *American Heart Journal*, 1933-1950; member  
of Editorial Board of *Circulation*, 1950—

Formerly member of National Advisory Heart Council (National Heart  
Institute, USPHS), 1949-1953

Author of about 45 articles on heart disease in medical journals and text books

Editor and co-author of "You and Your Heart" (Random House, 1950)





## THE PRESIDENT'S PAGE

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### A LETTER TO THE MEMBERS

A few days ago I was formally inducted into office as the 117th President of Connecticut State Medical Society in 162 years. I am content to remain in ignorance of the reasons that led to my selection, but this does not lessen in the slightest degree my gratitude for one of the great honors of my professional life. It is probably unnecessary to tell you that the nomination was accepted only after long and careful consideration, and even then with grave doubts about the wisdom of this decision. How could any physician *not* hesitate to accept an office that has such a proud record of self-sacrificing service on the part of scores of physicians through many decades? How would it be possible in one short year as President-elect to learn enough of the traditions, procedures, activities, and requirements of the Society to fit one even inadequately to perform the duties of the presidential office? These and other doubts made me pause, but the realization that many of my distinguished predecessors must have felt similarly gave me courage to accept.

To say that I am grateful and proud is to speak with notable restraint. My gratitude is increased by the recognition that this is not an empty honor, or one awarded for past achievement, but rather one that combines in an unusual degree the high privilege of acting as the representative of the medical profession of our State, an opportunity for service to physicians and the non medical public, and a challenge to help in making the Society even finer than it is now. It is my earnest hope that I may measure up to the high standards of unselfish devotion established by past presidents, and that the Society may grow steadily in stature and usefulness during the coming months. If that hope is to be realized, it will be only through the active help and cooperation of hundreds of members throughout the State; the loyal support of the other officers and of the Council is assured.

I cannot but wonder how many members are familiar with the stated purposes of the Society. Some of these, as stated in its by-laws, are: "to bring into one organization the medical profession of the State of Connecticut; to unite with similar societies in other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standards of medical education and to promote friendly intercourse among physicians; to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease, and in prolonging and adding comfort to life." Perhaps many members may be unaware of this splendid statement (as I was until a year ago); it is to be hoped that those who read it now



for the first time will share my pride and gratification in the principles that guide us as an organization. But they apply not only to an organized group; surely every physician must find support and satisfaction in the knowledge that he belongs to the only profession that is dedicated to the prevention and cure of disease and to making life more comfortable for others.

For several hundred years it has been a great privilege to be a physician. Think how the capacities for serving humanity have increased within the professional life span of many of us! Many recent developments have equipped us to render service beyond the wildest dreams of our predecessors: the discovery of antibiotics, the remarkable improvements in anesthesia, the increase in our knowledge of body chemistry and fluid balance, the almost miraculous achievements of psychiatry, and the bold advance of surgeons into areas hitherto regarded as forever beyond their approach. How thrilling it is to have even a small and indirect part of the spectacular accomplishments that have extended the average span of life in this nation by 25 years in the past half century! And what lasting reward there is in "adding comfort to life," in recognizing that it is not mere length of days, but also their fullness and richness that should inspire our efforts.

It seems altogether probable that even greater advances in medical science will be made in the near future. The medical profession must be deeply concerned that these advances shall be subjected to their most stringent tests and their most fruitful application by physicians in practice rather than by those in laboratories. And all members of the Society should be interested in ensuring that its progress keeps pace with that of scientific medicine. The Society is the creation of Connecticut physicians and is so organized as to be responsive to their desires. All physicians and all groups within the State can express their views through the officers and the Council, but too often in the past they have remained inarticulate and apparently indifferent to situations that might have a profound effect upon many aspects of medicine and medical practice. At present our profession is largely free from the controls and restrictions that exist in many other parts of the world, but there is no assurance that this liberty will continue without constant vigilance and preparedness on our part. The Society can do much to help in the preservation of this freedom, but only to extent that its members desire. I ask with all earnestness that those who have taken little or no interest in the Society or in the County Associations plan to participate actively for at least the current year, in full confidence that after a year the interest will not subside.

My year as your representative begins with a plea for your support and with the pledge that I shall strive earnestly to justify by my actions the trust that you have reposed in me.

H. M. Marvin, M.D.

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A REGIONAL PLAN FOR MEDICAL EDUCATION IN NEW ENGLAND

JAMES M. FAULKNER, M.D., *Boston*

THE purposes of a regional plan for higher education are to make provision for specialized or expensive forms of higher education within a region and by distributing the costs among the various states comprising the region to make available to them educational facilities which would otherwise be beyond their reach. Prominent in the thinking is the provision of wider opportunities for higher education of the youth of the region, but this is by no means the sole consideration. In the field of professional education for the healing arts, for instance, the local needs of the region for trained personnel must be a controlling factor in the planning. The general welfare of a region would not be best served by educating at the tax payers' expense a much larger number of professional personnel than can be absorbed into the economy of the region, particularly if such education is costly.

To restrict my remarks now to the field of medical education, it would appear to be the major objectives of a New England regional plan to insure as good opportunities for residents from all parts of this area to acquire a medical education as exist for residents of other parts of the United States and at the same time to insure a continuing supply of physicians adequate to meet the needs of the area.

Let us consider first the opportunities for medical education for residents of New England. Table I gives the ratio of freshman medical students (in all medical schools) to state population in 1952-53 in terms of students per 100,000 population.

TABLE I

FRESHMAN MEDICAL STUDENTS PER 100,000 POPULATION 1952	
Connecticut .....	4.4
Maine .....	2.5
Massachusetts .....	4.1
New Hampshire .....	3.2
Rhode Island .....	4.4
Vermont .....	4.8
New England .....	3.9
United States .....	4.7

Read at Second Regional Workshop, Medical-Dental School Commission of the Commonwealth of Massachusetts, January 29, 1954

The Author. *Dean, Boston University School of Medicine*

SUMMARY

Figures are presented which indicate that New England has become dependent on the rest of the country for the medical education of its residents to a degree which is cause for justifiable concern.

It is suggested that a regional plan for medical education in New England might afford the most practicable means for each of the New England States to provide suitable opportunities for medical education for its residents and at the same time to ensure a continuing supply of medical manpower adequate to its needs.

These figures indicate that all of the New England States except Vermont had a lower ratio of residents entering medical school than the United States as a whole and that the ratio for New England as a whole was well below the national average.

If New England had the same ratio of freshman students to population as the United States as a whole, we would have had 470 freshman in medical school that year. Actually, we had 412, or 58 fewer entering medical school in 1952 than might have been expected on the basis of population.

This is due partly to a relatively smaller number of applicants from New England and partly to a slightly lower ratio of acceptance to applications as compared to the country as a whole.

These figures suggest: (1) that New England is falling behind the rest of the country in getting medical education for its residents, and (2) if New England had the same ratio of medical students to



population as the rest of the country, the total number would exceed the capacity of the existing New England medical schools. A closer examination of the distribution of New England residents in the freshman classes of the New England medical schools in 1952 will give us a clearer picture of our resources.

TABLE II<sup>1</sup>

NEW ENGLAND RESIDENTS ADMITTED TO MEDICAL SCHOOLS  
IN 1952

	ALL SCHOOLS	N. E. SCHOOLS	BU	DARTMOUTH	HARVARD	TUFTS	VERMONT	YALE
Connecticut .....	94	37	3	4	3	15	1	11
Maine .....	21	16	2	1	0	6	6	1
Massachusetts .....	219	138	32	2	20	73	6	5
New Hampshire ....	19	13	1	0	0	5	4	3
Rhode Island .....	39	13	5	0	0	7	0	1
Vermont .....	20	17	0	1	1	0	15	0
Total .....	412	234	43	8	24	106	32	21
Total Yearly Classes		460	73	24	118	115	51	79

Table II gives the distribution of the New England residents in the freshman classes of the New England medical schools in 1952. It will be seen that there is considerable variation in the proportion of New England residents in the individual schools. Tufts, which virtually restricts its admissions to New Englanders, took in 106 New England residents which is 45 per cent of the total number of New England residents admitted to New England schools; Harvard, which deliberately fosters a policy of nationwide representation in its student body, has the smallest proportion of New Englanders; and the other schools lie in between.

Now to turn to the question of whether the output of the New England schools is sufficient to meet the medical needs of the area. One of the factors which makes this a very difficult question to answer is the fact that we do not operate in a closed economy. Tufts alone of the New England schools restricts its students to residents of New England.

Of the 412 New England residents accepted in 1952, 234 or 57 per cent went to New England schools. The total freshman enrollment of the New England schools was 460, of whom 234—or approximately 50 per cent—were New England residents.

TABLE III<sup>1</sup>

PHYSICIANS LICENSED TO PRACTICE IN NEW ENGLAND IN 1952  
CONN. MAINE MASS. N. H. R. I. VT. TOTAL

B. U. ....	7	3	32	4	3	0	49
Harvard .....	10	2	56	3	2	1	74
Tufts .....	15	4	57	3	11	1	91
Vermont .....	8	1	6	1	0	6	22
Yale .....	20	0	8	7	1	1	37
N. E. Schools.....	60	10	159	18	17	9	273
All Schools .....	195	33	290	44	30	25	617

Table III shows that in 1952, 617 physicians were licensed to practice in New England. Of these, only 273—or 44 per cent—were graduates of New England schools; 344—or 56 per cent—were graduates of schools outside New England; 668 graduates of New England schools were licensed to practice in the United States that year. Only 273 of them—or 41 per cent—chose to take out licenses in New England.

The figures confirm observations which have been made before that the location of the medical school where a physician gets his training is not a potent influence in determining where he settles to practice. Two factors are of importance in determining the distribution of physicians.<sup>2</sup> One is the economic condition of the area. New England with a relatively high per capita income is in a good competitive position in this regard. The second is the tendency of physicians to return to their home towns or nearby areas. This latter factor merits our serious attention. The figures indicate that a smaller proportion of New England residents are receiving a medical education than is true for the country at large. They also show that the majority of physicians now settling in New England have received their training elsewhere. We must ask ourselves whether this situation is a sound one, and whether in the long run it might not work to the disadvantage of New England. Would we not be in a safer position if we at least had the capacity to educate in New England as many physicians as are needed in this area. Considering the general financial instability of the privately supported medical schools throughout the country and the geographical restrictions which are imposed by most of the state schools, is it prudent for us to depend so heavily on the rest of the country for our medical education?

Two final questions are pertinent to this discussion: namely, (1) are we facing a doctor shortage in New England? and (2) would the establishment

of a regional compact serve to prevent such a shortage?

I do not propose to venture into the debatable ground of theoretically desirable doctor-to-patient ratios. Such overall statistical figures have little real meaning unless thoroughly analyzed. It is recognized that maldistribution of physicians is more of a problem than the total number in this area. There is a concentration of doctors in the larger cities to the detriment of some rural areas. This is not a problem which will be solved merely by graduating more doctors. It can be—and is gradually being—met by the development of improved facilities and hospitals in the small communities.

Without delving any further into the intricacies of the medical manpower problem, I would like to ask you to allow me to make some assumptions which seem to me conservative and which will bring us directly to the nub of our discussions. These are:

(1) New England is not at the present time oversupplied with physicians.

(2) It is desirable for the general welfare of New England that the number of residents of New England who are trained for the practice of medicine be not curtailed.

(3) That it would be prudent for New England to insure as a minimum that present facilities for medical education within its borders be maintained.

With these assumptions in mind let us then take a look at the existing facilities for medical education in New England and their outlook for the future. Of the six medical schools, one—Dartmouth—is a very

small two year school which is not an important factor in the medical manpower problem. Of the remaining five schools, only one—Vermont—is state-supported. This School, which has a capacity for training more than twice as many doctors as are needed in Vermont, is trying to work out agreements with Maine and New Hampshire for providing medical education for residents of those States. The remaining four schools are privately supported. They are all, I believe, running large deficits which are giving grave concern to their parent universities. They have made a contribution in medical education for New England which is beyond price—and at no expense to the tax payer. But for some of them at least the future is in doubt unless something is done to help them meet the heavy costs of medical education.

A regional plan which would pay the costs of medical education for residents of New England in existing schools would go a long way to assure the continued operation of our present institutions and would make some expansion feasible if that seemed desirable. This would undoubtedly be a more economical way for the states to obtain medical education for their residents than for each or any of them to set up an independent medical school of its own.

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## BILIARY CIRRHOSIS

W. G. LEEDS, M.D., and B. V. WHITE, M.D., *Hartford*Dr. Leeds. *Resident in Medicine, Hartford Hospital*Dr. White. *Associate Physician and Chief of Gastroenterologic Clinic, Hartford Hospital*

## SUMMARY

The authors review briefly the subject of biliary cirrhosis as it is encountered in a large, community, general hospital. Exemplary cases illustrating the two main clinical types of the disease are included together with a few instances of hepatic disease which for a time mimicked biliary cirrhosis. The importance of needle biopsy of the liver is emphasized.

PATIENTS with prolonged jaundice, pruritis, massive hepatomegaly, splenomegaly, xanthomatosis, pigmentation, osteoporosis, and late liver failure present a clinical picture which contrasts strikingly with Laennec's cirrhosis in which there is early evidence of severe parenchymal hepatic dysfunction. The term biliary cirrhosis is applied to this group of patients.<sup>1</sup> Any of several pathologic sequences<sup>2,3</sup> may give rise to this syndrome, including cholangitis, pericholangitis, congenital absence of the bile ducts. Alterations in cholesterol, bile, protein, and calcium metabolism which occur in biliary cirrhosis, of whatever etiology, lead to clinical and late pathological changes which lend to the syndrome a considerable degree of specificity. From a practical standpoint those cases caused by frank extrahepatic obstruction are considered secondary to the obstructing lesion. All the other types may be grouped together under the designation of primary biliary cirrhosis.

Ahrens<sup>1</sup> and his coworkers studied 12 patients with primary biliary cirrhosis and 20 with the secondary form of the disease. They found certain additional characteristics:

(a) Elevation of serum lipids. This was present in all cases, with a large increase in the phospholipid fraction.

(b) Xanthomatosis. This finding was noted only

in those patients with the greatest serum lipid elevations. A critical level of 1800 mg. per cent was established, below which xanthomata did not occur.

(c) Steatorrhea. There was an extreme defect in intestinal fat absorption with an increase in stool fatty acids and soaps.

(d) Generalized osteoporosis. Associated pathological fractures were common.

(e) Increased basal metabolic rate in the absence of evidence of hyperthyroidism.

(f) There was an inverse relationship between deposition of lipid in skin and arteriosclerosis of the intima of arteries.

A review of the medical records at the Hartford Hospital between 1947 and 1952 revealed 7 cases of secondary biliary cirrhosis and one case of the primary type. In addition there came to light the records of three patients having laboratory evidence suggesting biliary cirrhosis, but whose subsequent courses did not bear out this diagnosis. These cases are included here because they point up the fact that conditions such as infectious hepatitis and Laennec's cirrhosis can mimic biliary cirrhosis in many respects. Two of them were clinically well in 6 to 8 weeks, and probably had acute infectious hepatitis with unusual laboratory findings. The features of these cases will be discussed later.

In the secondary group there were 4 males and 3 females. Their ages varied from 48 to 90 years. The causes of biliary obstruction were:

Carcinoma of the head of the pancreas.....	2
Carcinoma of the ampulla of Vater.....	1
Common duct stone.....	3
Common duct stones with scarring of the distal portion of the common duct and scarring of the right hepatic duct	1

The duration of jaundice from onset until the diagnosis of biliary cirrhosis was made varied from 5 weeks to 3 years. All the diagnoses in this group were established at operation or autopsy. The alka-

line phosphatase activity varied from a low of 9.9 to a high of 58.4 Bodansky units, and the serum bilirubin from 3.4 to 38.8 mg. per cent. In only two cases was the prothrombin time significantly prolonged. The urinary urobilinogen was normal in 2, decreased or absent in 3, and not recorded in the other 2 cases. The cephalin-cholesterol flocculation test was significantly abnormal (2 plus or higher in 24 and 48 hours) in 2 of the 7 cases. In one case this abnormality occurred only after several years of obstruction. The serum cholesterol was elevated in the two cases in which this test was made.

The following case is characteristic of secondary biliary cirrhosis:

#### CASE NO. 1

S. G. This white Hebrew woman was well until 1937 (age 35) when she began to experience bouts of colicky right upper quadrant pain which were diagnosed as acute cholecystitis. In 1942 (age 40) following one of these bouts associated with jaundice, a cholecystectomy and common duct exploration were done. No stones were found in the gallbladder or in the common duct. Postoperatively the jaundice persisted and the patient continued to experience right upper quadrant pain. In February, 1945 (age 43) the patient was re-explored at another hospital, and several stones were removed from the common bile duct. In December of that year the patient was again hospitalized because of jaundice and pruritis. The icteric index was 50, the serum bilirubin 12.8 mg. per cent, the cephalin-flocculation test 2 plus in 48 hours, the prothrombin time normal, and the total protein 6.1 Gm. per cent. Abdominal exploration revealed scarring of the distal portion of the common duct. A probe could not be inserted into the right hepatic duct because of either stenosis or angulation. The liver was enlarged, smooth, and firm. Although a T tube was left in place, jaundice persisted, but the itching was much relieved. In 1946 (age 44) the patient was again explored in another city, and a new T tube introduced. Biopsy of the liver showed evidence of cirrhosis. The common duct exploration was negative. In 1947 (age 45) the patient developed edema and ascites. In April, 1948 (age 46) she was treated with salt poor human serum albumin, and the T tube was irrigated with "TWEEN-80." One month later the patient developed massive hematemesis. From this time on the patient presented the picture of chronic jaundice, edema, ascites, spreading xanthomata, increasing back pain due to osteoporosis, and gradual emaciation. She was hospitalized many times for treatment with salt poor human serum albumin which frequently relieved the ascites, edema, and back pain. There were two more episodes of hematemesis between 1948 and 1950. By 1951 (age 49) it was becoming more and more difficult to establish diuresis. Laboratory studies during this period revealed persistent elevation of the serum bilirubin, alkaline phosphatase, and cholesterol. Total proteins were persistently low with a reversed albumin:globulin ratio except after treatment with serum albumin. Finally the patient's course was more rapidly downhill, and after a short period of coma

she expired on March 18, 1951. The gross findings at autopsy were:

1. Biliary cirrhosis, secondary to cholecystitis and cholangitis, with permanent choledochostomy.
2. Portal hypertension with esophageal varices, hemorrhoids, ascites, splenomegaly and edema.
3. Pulmonary edema.
4. Cholecystectomy.
5. Obstructive jaundice.
6. Extreme osteoporosis with fractures of the ribs and spine.
7. Coronary sclerosis.
8. Incisional ventral hernia.
9. Malnutrition.

After microscopic examination of tissues, the final diagnoses were:

1. Acute and chronic cholangitis (intrahepatic) with cirrhosis.
2. Bronchopneumonia.
3. Jaundice, obstructive.
4. Splenomegaly, esophageal varices, hemorrhoids, and ascites.

The three cases suspected initially of having biliary cirrhosis may be summarized as follows:

#### CASE NO. 2

A thirty-seven year old white male was admitted because of six weeks of jaundice, anorexia, weight loss, dark urine and clay colored stools. Physical examination was negative except for the presence of jaundice. The serum bilirubin was 9.0 mg. per cent, sedimentation rate 87 mm. per hour (Westergren), urine urobilinogen positive in dilution of 1:160; cephalin flocculation negative in 24 and 48 hours, alkaline phosphatase 13.4 Bodansky units, and serum cholesterol 116 mg. per cent. The patient recovered on rest and a nutritious diet after a period of eight weeks. In the spring of 1953, nine months after his illness, he was well. This patient is thought to represent a case of infectious hepatitis with an extreme obstructive phase.

#### CASE NO. 3

A forty-six year old white woman was admitted to the Hartford Hospital because of one week of jaundice, itching of the skin, nausea, anorexia, and dark urine. Physical examination revealed jaundice and moderate hepatomegaly. The serum bilirubin was 11.2 mg. per cent, cephalin flocculation negative in 24 and 48 hours, prothrombin time within the normal range; alkaline phosphatase 58.1 Bodansky units, serum cholesterol 932 mg. per cent, total protein 7.6 Gm. per cent with a normal albumin:globulin ratio, and sedimentation rate 111 mm. per hour (Westergren). Exploration failed to reveal any extrahepatic obstruction, and a liver biopsy taken at the time of operation revealed cholangitis. The patient recovered in six to eight weeks and remained well. After the negative exploration this patient was thought to have primary biliary cirrhosis, a diagnosis which was subsequently disproven by a complete recovery within two months. She presumably had infectious hepatitis with clinical and laboratory signs of obstruction.



## CASE NO. 4

A fifty-three year old white male was hospitalized with a six months history of weight loss, low grade fever, anorexia, light stools and dark urine. He admitted taking eight to fourteen glasses of beer per day for many years. Physical examination revealed jaundice, spider angiomas, and slight hepatic enlargement. The serum bilirubin was 5.5 mg. per cent; total protein 6.6 Gm. per cent with a reversed albumen:globulin ratio; cephalin flocculation negative in 24 and 48 hours; prothrombin time within the normal range; sedimentation rate 114 mm. per hour (Westergren); alkaline phosphatase activity 25.0 Bodansky units. Surgical exploration failed to reveal any evidence of extrahepatic biliary obstruction, and liver biopsy done at the time of operation revealed bile stasis. No follow-up information is available, but this patient is thought to have had early Laennec's cirrhosis.

The following case is considered to be an example of primary biliary cirrhosis:

## CASE NO. 5

V. J. This white widow with no history of exposure to toxic agents was essentially well until May 15, 1949 (age 65) when she noted dark urine and light stools. She was hospitalized on July 29, 1949 in another city. On surgical exploration the gallbladder was normal and the common duct not dilated, although there were several succulent lymph nodes along its course. The surface of the liver was described as granular. The patient's clinical course was not altered by the surgical procedure. In the ensuing two months this jaundice persisted and hepatomegaly was first detected.

On November 6, 1949, the patient was admitted to the Hartford Hospital still suffering from pruritis, asthenia, dark urine, clay colored stools, and weight loss of 16 pounds in five months. On physical examination there were no liver palms, spider angiomas, ascites, or collateral vein dilation. The liver and spleen were both palpable. The serum bilirubin varied from 7.1 to 14.8 mg. per cent. The cephalin flocculation test was 2 plus in 24 and 48 hours. The alkaline phosphatase was 52.7 Bodansky units, the total protein 7.9 Gm. per cent (albumen 4.2, globulin 3.7), the prothrombin time 60 per cent of normal and the serum cholesterol 980 mg. per cent. The stools and urine were positive for bile. On November 10 the patient was seen by one of us (B. V. W.) and biliary cirrhosis of the secondary type seemed most likely. Accordingly the patient was re-explored on November 15, 1949. The liver was enlarged with rounded margins and was bile stained. The surface was slightly irregular but not "hobnailed." The gallbladder contained no stones and the common duct was not dilated. There was a large rubbery lymph node measuring 2.5 cm. by 1.5 cm. posterior to the common duct which was opened and explored. A T tube was left in place, and a subsequent cholangiogram was negative. Specimens of liver and of lymph node were taken for biopsy.

The sections of the liver showed evidence of extreme bile stasis with bile thrombi in many of the canaliculi. The liver cells were well preserved but there was a slight increase in periportal fibrous tissue together with periportal infiltration by leukocytes of the lymphocytic and polymorphonuclear series.

The lymph node appeared to be the site of chronic lymph adenitis. Hepatitis of the cholangitic type appeared to be the most likely diagnosis. Six weeks after discharge from the hospital in January, 1950 Mrs. J. was seen by one of us. At this time she was deeply jaundiced and suffering from intense itching. The serum bilirubin was 15 mg. per cent, thymol turbidity 10.5 units, cephalin flocculation negative, and hematocrit 39 per cent.

During the ensuing two years her condition progressively deteriorated. She developed ascites, edema, and repeated hemorrhages from various mucous membranes. The hemorrhagic diathesis always responded to vitamin K therapy.

On July 28, 1952, she was admitted to another hospital in a state of stupor with mental confusion varying from lethargy to the verge of coma. On physical examination the liver and spleen were palpable and the gums were spongy and bleeding. Emaciation, edema, and extreme jaundice were evident. The skin was brawny and excoriated. Pertinent laboratory procedures included thymol turbidity 3.0 units and cephalin flocculation 4 plus in 48 hours. The patient gradually lapsed into deep coma and expired on August 26, 1952. The final clinical diagnoses were (1) cholangitis, severe, progressive, with jaundice and (2) cirrhosis with jaundice.

## DISCUSSION

Although primary biliary cirrhosis is a rare disease seldom encountered in a community hospital, there are occasional patients with laboratory evidence of obstructive jaundice which mimicks this entity. Some such patients appear to have self limited hepatitis of the cholangiolitic variety (cases 2 and 3) and others have atypical manifestations of Laennec's cirrhosis (case 4). Still others, not included in this series, have neoplastic or other mechanical obstructions of the hepatic ducts overlooked at exploratory laparotomy. At the same time prolonged obstructive jaundice may lead eventually to a clinical state indistinguishable from the primary form of biliary cirrhosis (case 1).<sup>1,2,3</sup> In fact, evidence of hepatic damage may be noted as early as five weeks after the onset of obstruction. These observations have importance in considering indications for surgery in those cases with laboratory evidence of obstructive jaundice without supporting clinical evidence. Surgical exploration is contraindicated in hepatitis, yet failure to explore may be hazardous after the fifth week. For these reasons every effort should be made to establish a diagnosis shortly after the onset of jaundice. It is during this early phase that the various hepatic function tests are least likely to be misleading. Short of laparotomy, needle biopsy of the liver may be the only means of differentiating hepatocellular disease from biliary tract obstruction. Unless specifically contraindicated this procedure

should precede surgical exploration in all doubtful cases of jaundice.

#### CONCLUSIONS

(1) Although biliary cirrhosis may result from any of several etiologic factors, within or outside the liver, the final clinical and pathological manifestations are quite constant.

(2) For practical purposes it is convenient to think of primary biliary cirrhosis as including all those forms not associated with extrahepatic obstruction.

(3) It is important to differentiate from biliary

cirrhosis other conditions such as infectious hepatitis of the cholangiolitic type which may run a relatively short, self limited course.

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## SUBCLINICAL SPRUE SYNDROME

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THE clinical sprue syndrome is a gastrointestinal derangement, characterized by deficient absorption of fat, glucose, certain vitamins and calcium, and deficient secretion of the intrinsic haemopoietic factor. Current medical literature has not thrown significant light on the understanding of this disease.

We have high standards of diagnostic criteria for sprue. These criteria include: glossitis; diarrhea—voluminous foul smelling, frothy, liquid, and yellow; weight loss of at least 20 pounds over a 6 month period; macrocytic anemia with a red blood cell count of 2.5 million or less, and a color index of 1.0 or more; megaloblastic bone marrow; free hydrochloric acid in the gastric juice after injection of histamine; a flat oral glucose tolerance curve; serum calcium 8.5 mg. or less; and normal serum levels of amylase and lipase. By the time these criteria are satisfied, the disease is far advanced.

Sprue is a very insidious and often latent deficiency state, in a very broad sense, reflecting the presence of latent or progressing physiological alterations or pathological conditions in the gastro-intestinal tract. This deficiency state has to complete a very long vicious cycle before the patient arrives at the

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#### SUMMARY

The clinical sprue syndrome is defined and its signs and symptoms outlined. The protean nature of the syndrome is emphasized with special attention called to the subclinical stage. The various stages in the development of this latter stage are discussed. Amebiasis enters into the picture and emphasis is placed on the necessity for treating the asymptomatic amebiasis cases.

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status of classical sprue. Fortunately a very small percentage of cases reach the full proportions of sprue as described in the text books.

Subclinical sprue syndrome is a border line deficiency state in the broadest sense, producing such poorly defined symptoms as anorexia, loss of strength, indigestion, diarrhea, nervousness, irritability, extremely vague discomfort in the lower abdomen, nausea, flatulence, heartburn, or excessive salivation, the symptoms being single or combined but not interfering with the routine work of the



person. The patient with these early manifestations of the subclinical sprue syndrome is a type who attends to his work but feels uncomfortable due to any or a combination of the many ill defined leading symptoms enumerated above. Too frequently the patient is told "There is nothing physically wrong with you." This is indeed a grave mistake on the part of the doctor; for in the early stage of the subclinical sprue syndrome timely treatment is highly effective, and the patient carries on with his routine of work and social responsibilities. This is extremely important in view of the wage earning and productive capacity of the individual. In my private practice at my clinic in Madras the following observations were made during a period of three years. The selected cases for observation were residents in the city.

#### PROTEAN NATURE OF THE SYMPTOMATOLOGY

Sprue is both tropical and nontropical. The ill defined and protean nature of the symptomatology is the characteristic feature of sprue syndrome. The incomplete clinical picture is common and the classic syndrome is comparatively rare. It is at the sub-clinical stage that much can be done, and therefore it is worthwhile to look out for this condition.

The following are the unimpressive and ill-defined stages through which subclinical sprue syndrome may reach the clinical state of classical sprue.

#### FIRST STAGE OF DEVELOPMENT

(1) Young adult, fairly well made, usually belonging to the working class. The ill-defined symptoms are (1) anorexia, (2) indigestion—on and off, (3) hurried one or two loose motions, (4) very slight discomfort after meals and a vague feeling as if he or she should evacuate the bowels. This patient usually keeps fit from his point of view and does his usual work. But he has a definite sense of dissatisfaction regarding his health—because of the above mentioned symptoms. He consoles himself that his vague symptoms are due to excessive cigarette smoking, bad type of vegetables, severity of summer, failure of monsoon, etc. This is the stage when the subject himself may not be inclined to consult his family doctor; at least he may not consult the doctor primarily for these symptoms. He may accidentally relate his vague symptoms in still more vague language when he seeks medical care and treatment for something else such as an attack of "flu," chest cold, etc.

#### SECOND STAGE OF DEVELOPMENT

Adult, usually a female. The following are the vague complaints:

- (1) Moving the bowels with a sense of urgency immediately after food twice or once daily.
- (2) Sickening feeling of abdominal discomfort. If the subject happens to be a working girl, she may in her hurry to reach her work avoid taking her meal, for she is afraid of the sickening feeling of abdominal discomfort associated with the bowel movement with a sense of urgency which follows immediately after food. This fear complex makes things worse. The patient grows irritable and nervous. This stage of subclinical sprue syndrome is not entirely devoid of impression on the patient, but the patient may fail to impress the doctor with his or her symptoms. The subject still continues to work but probably avoids social functions. This indeed is a hopeful stage in which the patient can obtain complete relief and ultimate cure without interfering with daily work. This is the stage where the wage earning capacity, and routine social and emotional activities are not interfered with. This phase of subclinical sprue syndrome is more marked in women than men and the women do not usually come out straight with the above complaints. One has to look for it among his patients and keep suspecting the existence of subclinical sprue syndrome as a much commoner deficiency stage than we are inclined to believe.

#### THIRD STAGE OF DEVELOPMENT OF SUBCLINICAL SPRUE SYNDROME

Adult—commonly a young pregnant woman complains of:

- (1) Soreness of tongue when hot or spicy food is taken.
- (2) Certain amount of smarting sensation of the tongue for certain articles of food that were previously well received.
- (3) Excessive salivation.
- (4) Dyspepsia.
- (5) Mild flatulence.
- (6) Vague pain of calf muscles.
- (7) Irritable temper (particularly noticed in cases who previously enjoyed sweet temper).
- (8) Definite abdominal discomfort after food.
- (9) Uncomfortable sense of urgency while passing motion.
- (10) Malaise.

This symptomatology may be termed the sore tongue phase of subclinical sprue. This phase of the subclinical sprue syndrome is less vague and has more chance of making an impression on the patient and the doctor. Even at this stage the subject may continue to work. On close examination of the tongue, pin head areas of epithelial desquamation are made out. The extent of such areas does not usually correspond to the extent of the smarting. Mild flatulence, heartburn, and the smarting tongue render the patient able to eat less and lead to the development of a certain amount of aversion for food. This is a stage wherein there is still a good chance to correct the subclinical sprue syndrome and stop the patient from developing classical sprue.

Just as subclinical beriberi is accepted and treated widely, the subclinical sprue syndrome should be accepted. After having accepted and treated the state of subclinical beriberi one rarely comes across a typical case of classical beriberi even in areas like Andhara State in South India where it formerly was common to have large number of cases of beriberi. This indeed was a very sad state of affairs. But now one rarely comes across a case of beriberi of textbook description. In the light of the above analogy it is worthwhile to accept the idea that there is a state of subclinical sprue syndrome which can be treated effectively.

It has been observed in my series that those patients who did not submit to treatment while they were diagnosed as subclinical sprue syndrome invariably developed parasprue and in some instances typical sprue within one year. Sprue is not necessarily a tropical disease although it is prevalent in the tropics. It is a deficiency state in the broadest sense. Just as tuberculosis and rheumatic fever can be quiescent, sprue can be quiescent. Therefore, the subclinical sprue syndrome can be accepted as the initial stage of classical sprue.

## II. THE ROLE OF AMEBIASIS IN THE PICTURE OF SUBCLINICAL SPRUE SYNDROME

Recent epidemics have forcibly brought to the attention of the medical profession the fact that amebiasis can no longer be considered solely a tropical or subtropical disease. Surveys indicate an infestation rate even in the United States, with good sanitation of about 10 per cent, higher in some southern localities.

In the tropics and particularly in India the incidence is about 60 to 70 per cent, an alarming figure indeed.

Amebiasis is an infectious disease caused by *Endameba histolytica*. In most cases, the multiplication of the parasite is limited greatly by the resistive powers of the host. Despite the exceedingly high incidence of infestation the number of cases diagnosed as such is amazingly small. The following factors are largely responsible.

1. Infestation with *Endameba histolytica* often gives rise to few significant symptoms.

2. The great variety and mildness of its vague symptoms usually preclude clinical diagnosis. The following are the common diagnostic criteria.

- i. Observation of motile forms or cysts of *Endameba histolytica* in stool specimens (repeated examinations are necessary).

- ii. Recovery of *Endameba histolytica* by means of the proctoscope from the intestinal mucosa.

The necessity for treating symptomatic types of amebiasis is of course generally accepted. We have dealt with the diagnostic criteria and the percentage of infestations in tropical, subtropical, and temperate climates. Amebiasis is so widespread that we are obliged to take into consideration the existence and importance of asymptomatic amebiasis.

To enable us to appreciate the importance of asymptomatic amebiasis the following points may be considered.

1. Many cases of amebiasis are asymptomatic.
2. The clinical course is extremely varied and subtle.
3. In not all cases infected with amebiasis can the ulcers be demonstrated.
4. Amebic ulcers probably attain a considerable size long before symptoms appear.
5. Amebic ulcers can exist in a latent or quiescent stage for many years without producing typical dysentery.

6. The incipient pathological changes of asymptomatic amebiasis contribute to or initiate alterations in the physiological condition of the gastro-intestinal system, particularly in relation to absorption of vitamins and certain minerals.

In view of the fact that:

- i. Prevalence of amebiasis is tropical, subtropical and also temperate.



ii. Symptomatic type of amebiasis is only a small percentage of the infected cases.

iii. Even symptomatic amebiasis runs a variable and subtle clinical course—we are obliged to take a positive approach in evaluating asymptomatic amebiasis.

What is the purpose in dealing with asymptomatic amebiasis in connection with the subclinical sprue syndrome? We shall consider the close inter-relationship of these conditions in an apparently healthy subject exhibiting ill defined vague gastrointestinal disturbances.

In my series of observations I have noted the following:

1. Asymptomatic amebiasis conditioning subclinical sprue syndrome.

2. Coexistence of asymptomatic amebiasis and subclinical sprue syndrome giving rise to the symptom complex of subclinical sprue syndrome, not ameliorated either by treatment for sprue syndrome or by treatment for amebiasis singly but cured with the combination of both the treatments together. The percentage incidence of cases of this type is

great in AngloIndian, Eurasian, American, and other western missionary workers in India.

In view of the above observations on the extent to which the subclinical sprue syndrome is responsible for many of the vague gastro-intestinal disorders commonly seen in ambulatory practice, one may not be able to resist putting it the other way round. How many cases of vague gastrointestinal disorder seen in ambulatory practice are really cases of subclinical sprue syndrome.

To what extent does asymptomatic amebiasis co-exist with subclinical sprue syndrome in giving rise to the symptom complexes of gastrointestinal disorder so common in ambulatory practice?

To what extent do these conditions, for which we have effective methods of treatment, go unnoticed, unsuspected, or undiagnosed in the subjects attending our outpatient departments?

As there is nothing dramatic in the symptoms to frighten the patient or to enthuse his doctor, the widely prevalent subclinical sprue syndrome is not dealt with aggressively in a stage when it can be completely cured, and thus undo the chances of developing into classical debilitating sprue.

## ORBITAL UNDERCUTTING

## IN THE TREATMENT OF PSYCHONEUROSIS AND DEPRESSIONS

## Results of fractional lobotomy in the milder emotional illnesses

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FIVE years ago the writer presented a new method of fractional lobotomy, permitting precise isolation under direct vision of various areas of frontal lobe cortex by means of cortical undercutting. The results, chiefly in schizophrenic patients, were summarized in 1951. Undercutting of the inferior or orbital surface of the frontal lobes has been carried out in 112 cases, and it was noted that when undercutting was limited to this area, no appreciable personality blunting or deficit occurred. This has recently been confirmed by the studies of Rylander and Sjoqvist. For this reason, selective cortical undercutting of the orbital surface of the frontal lobes has been done in 34 cases of the milder emotional and mental illnesses, including obsessive-compulsive neuroses, anxiety-tension states, somatic conversions, cyclic depressions, and senile emotional disturbances. The results have been gratifying in all categories, resulting in a lessening of anxiety and tension, a fading of morbid obsessive thinking, a lightening of mood, frequent strengthening of male libido, and relief from drug and alcohol addiction provided they are secondary to anxiety or panic states. Fractional lobotomy should not be performed on constitutional alcoholic, psychopathic or criminal types.

To our surprise, the senile emotional disturbances have shown the greatest benefit, to such an extent as to warrant a separate report. The degree of improvement in all categories has been in the following diminishing order: (a) senile emotional states, (b)

depressions and affective illnesses, (c) psychalgias, and (d) physical conversion states including headache, tinnitus, vague pain and ulcerative colitis. There have been no adverse effects in the release of hostility or loss of social sensitivity except for an uncovering of an underlying schizophrenia, which occurred in seven out of thirty-four cases. These have been aptly labeled pseudoneurotic schizophrenia by Hoch. Eventual benefit occurred to both the neurotic overlay and the psychosis. There have been no infections, one death from coronary thrombosis, 5 per cent isolated convulsions permanently arrested by dilantin. In contradistinction to standard lobotomy, improvement is insidious without any abrupt change in the overall personality.

In brief, it appears that the older the patient the more the benefit by any form of lobotomy sufficiently limited to prevent personality deficit. Orbital undercutting has been selected as causing the least deficit. In those agitated, sleepless and involuntarily incapacitated by the destructive processes of old age, deliberate further destruction of a portion of the frontal lobe has restored them to a happy and frequently useful existence. Report is made of twelve cases undergoing undercutting of the inferior or orbital cortex of the frontal lobes in persons over that age listed by the social security act as "old." Seven have been 70 years or over, and three over 80 years in age. Benefit occurred in all cases.

Mention is made of additional aged cases which have undergone other types of modified lobotomies, obtained through the courtesy of our psychiatric and neurological confreres.

*Summary of address at Yale University School of Medicine, January 11, 1954*



## ANO-RECTAL PROCEDURES

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A CHINESE patient once told me that there is an old Chinese saying that nine out of ten people have hemorrhoids. I replied by telling him that I felt that this was an understatement; that in my opinion ninety-nine out of one hundred adults have hemorrhoids at some time in their lives! It may not be possible to prove this statement and I do not find any statistics available, nonetheless it is probable that the estimate is not far from correct. There may not be any symptoms, or the individual may have symptoms at some time or other, so slight that he may not seek medical attention, or he may apply some patent medicine or placebo. However, the chances are that an enormous percentage of people, if examined, would show at least slight or moderate hemorrhoids.

It is not necessary in this paper to relate the technique of hemorrhoidectomy. This has been described many times in various works on proctology, and there are many operations of choice. In some works, such as Nesselrod's book,<sup>1</sup> only one operation is described and this in great detail. Other books, such as Bacon's earlier editions<sup>2,3</sup> and his latest two volume opus,<sup>4</sup> describe many operations and leave the choice to the surgeon. They even describe the clamp and cautery operation, of which more will be said later. The purpose of this paper is not to duplicate these descriptions but to tell of some of the maneuvers used by the proctologist or surgeon who has been trained by proctologic surgeons. These methods help to eliminate complications, minimize postoperative pain and discomfort and hasten convalescence. The procedures to be described are those which evoke questions from physicians looking over one's shoulder such as "Why don't you stretch the sphincter?" or "Why use adhesive tape instead of a T-bandage?" etc.

### POSITION OF THE PATIENT

There are three positions of choice in doing a hemorrhoidectomy and their use is dependent on three factors, the custom of the proctologist, the condition of the patient, and the type of anesthesia. The oldest position is the left lateral or Sim's posi-

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### SUMMARY

A description is offered of some of the methods commonly used by the proctologist. These procedures are helpful in relieving postoperative discomfort to a large extent and in diminishing some of the commoner complications following ano-rectal operations.

The rationale for the use of most of these methods is described.

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tion. This position is rather difficult to use unless one is well accustomed to it. The lithotomy position is still chosen a good deal. In this position it is advisable to have the patient placed well down on the table and the stirrups extended horizontally as much as possible without over abducting the thighs. The great difficulty in using this position is the habitual error on the part of operating room attendants of placing the stirrups parallel to the length of the table.

Recently the prone or jack knife position has been introduced and is now very commonly used. Of course some patients, because of their physical condition, cannot assume this position. On the other hand, because of arthritis of the hip or spine, or a disc operation, the lithotomy position at times cannot be used.

The variety of anaesthesia also governs the choice of position. The anaesthesiologists do not like to give general anaesthesia when the patient is prone, so the lithotomy position is chosen. There may be objection to the prone position for some kinds of spinal anaesthesia, although if time is allowed for the anaesthesia to "set" this objection is obviated. For teaching purposes the jack knife position is best, as the assistant can get as good a view of the operation as the surgeon. In the case of the conscious female patient the jack knife position offers the advantage of less ex-

posure of the genitalia and eliminates the discomfort of having the legs elevated in stirrups. Consequently there are many factors entering into the choice of the position used in doing a hemorrhoidectomy.

#### ANESTHESIA

In this day of specialization, choice of anaesthesia rests with the anaesthesiologist. Most men prefer a low spinal as it gives perfect relaxation. At present there seems to be a trend toward the use of low spinal and light intravenous anaesthesia simultaneously. While I do not want to enter into a controversy with the anaesthesiologist, it seems to me that supplementing spinal with a general anaesthesia is unnecessary and defeats the purpose of the spinal; in other words why subject the patient to the discomfort (slight though it may be) of a spinal, and the risks accompanying a general anaesthesia. Rather, I prefer intravenous pentathol sodium alone. It is well known that the latter drug does not give adequate skin anaesthesia, but the use of an oil soluble anaesthesia at the beginning of the operation gives sufficient skin anaesthesia for operating. It is customary for me to use 5 to 8 cc. of oil soluble anaesthetic, injected deeply and with care to avoid pooling. It is my opinion that the danger of abscess formation with the use of oil soluble anaesthetics is greatly exaggerated and that if the solution is properly injected, complication is minimal. Injection of the solution at the beginning of the operation gives the surgeon additional anaesthesia for the operation and the landmarks are not obscured. While the anaesthesiologists will not agree on the following point, the author does not like cyclopropane anaesthesia as it seems as though there is much more capillary bleeding with this type of gas.

#### DILATING THE ANAL SPHINCTER

It is the belief of the author that dilating the sphincter is not required in the majority of hemorrhoidectomies. With proper anaesthesia the anal margins may be retracted by traction with four Allis clamps. However, for good exposure, it is essential that each assistant hold a clamp in each hand until the landmarks are established and the hemorrhoids exposed. With careless assistants who are wont to hold two clamps in each hand a good text book exposure is next to impossible; therefore it is advisable to have both an assistant and a scrub nurse at the operation.

There are several reasons for not dilating the sphincter, aside from the fact that the proctologist

does not usually find it necessary to do so. In the first place stretching the sphincter is of course a stimulus to the patient and naturally necessitates the administration of additional anaesthetic. This is not important when a spinal anaesthetic is given, but with an intravenous or inhalation type of anaesthesia, sphincter dilatation becomes an important factor.

There are several other arguments against dilating the sphincter. One is the possible danger of over stretching the muscle with ensuing paralysis of the sphincter. This may result in temporary or permanent anal incontinence. Moreover, dilating the sphincters too rapidly or with too much enthusiasm may cause tearing of the muscle, again with subsequent incontinence.

A general surgeon of the so-called "old school" who once came to our medical school as a visiting professor of surgery told me that he never had any difficulty after dilatation. After watching him do a hemorrhoidectomy I realized that what he had said was true. I have never seen such care used in dilating an anal sphincter and I am sure that if all surgeons would take the time (which seemed at least like fifteen minutes to me) in carrying out this maneuver, one would have no fear of tearing the fibers of the sphincter muscles.

Another complication due to rough treatment of this muscle is the formation of a hematoma of the perianal region which may result in abscess formation. There is also the academic consideration of the fact that trauma to the hemorrhoidal plexus may liberate a minute quantity of intima and there is a chance that this is responsible for the most common complication following hemorrhoidectomy, phlebitis.

The latter factor leads to the question of the application of clamps to hemorrhoids at operation. The author is of the opinion that application of clamps to hemorrhoids also may cause trauma to the intima of the veins to which they are applied and this too may be an etiological factor in the occurrence of phlebitis. While in occasional cases it is convenient to apply a clamp, especially in the case of an exceptionally large hemorrhoid which requires suturing, all that is necessary usually is to place a suture on the base of the hemorrhoid. After dissecting the hemorrhoid this suture is tied around the stump before excising the pile.

#### THE CLAMP AND CAUTERY OPERATION

While this operation was formerly very popular, it has gradually fallen into disrepute in the last thirty



years. The causes for using a cautery were formerly quite valid. Before the days of aseptic surgery and of modern hemostasis, the hot iron was used because it was both a hemostatic and an antiseptic method of excising hemorrhoids. Of course it is now unnecessary to use this method to insure an aseptic operation, nor is it necessary to seal off the blood vessels with a red hot cautery. One of the objections to this operation is the use of clamps on the veins which has been discussed. Besides this there is quite a bit more pain when the pile is burned off (a burn is always more painful than a cut). In addition the skin and mucosa for several millimeters from the incision are burned even with the best and most carefully applied insulation. This area becomes necrotic and very frequently causes added scar with resulting stricture formation.

#### THE RECTAL PLUG

The author has never seen the necessity of using the so-called rectal plug or "whistle"—in fact since 1947 he has not inserted a drain of any kind into the anal canal after hemorrhoidectomy. The only time when anything is left in the anus postoperatively is in the case of excessive capillary bleeding. Then a small piece of gelfoam is inserted. This is soft and is of small bulk giving a minimum of discomfort. The main reason for not using a drain or a plug (aside from not needing one) is the fact that a packing is the biggest factor in the cause of postoperative pain after hemorrhoidectomy. Ordinarily inserting the finger or even a small instrument into the normal anus is unpleasant, if not painful. Naturally after an operation the insertion of the usual sized pack is downright criminal; and the removal of this pack is as painful as another operation. The following comments regarding the use of rectal plugs are both pertinent and interesting. At the meeting of the American Proctologic Society in 1949 a proctologist described the use of sodium pentothal in removal of rectal packing. In discussing this paper Dr. L. J. Hirschman said,<sup>5</sup> "We certainly never would give pentothal to remove a rectal pack. I thought that rectal packs went out about the same time that slavery was abolished. My good friend Sam Gant once said, 'You know, I'm a surgeon; I am not a taxidermist. I don't stuff the bird like a taxidermist does'."

Immediately following this discussion Dr. M. S. Pruitt of Atlanta, Georgia, said,<sup>5</sup> "I also would like to add my condemnation of the use of the rectal

whistle. Rectal packs have caused more pain, urinary retention, abdominal distention and general discomfort to the patient than any other one thing in ano-rectal surgery."

Instead of inserting a rectal pack after operating some surgeons are accustomed to place a piece of rubber tubing wound with plain iodoform gauze in the anal canal. This is supposed to act as a hemostatic and to allow expulsion of gas and blood if there should be excessive bleeding. This instrument of torture has also been discarded by the proctologist. I have a letter from the late Dr. Jerome Lynch, who was partly responsible for introducing the so-called "whistle," which seems interesting enough to quote. Dr. Lynch wrote me in 1949,<sup>6</sup> "I certainly was surprised to know that you were interested in one of my early mistakes, namely the 'whistle.' The original idea was created by Dr. Pennington of Chicago and my idea was a development of the Pennington contraption. It was originally described in one of the New York medical papers, but I do not remember which one. A little experience with the 'whistle' was enough to convince me that I was on the wrong track and in some papers I wrote subsequently I apologized for the regrettable error.

"I have no objection to your mentioning this as one of my early ideas."

#### POSTOPERATIVE DRESSINGS

A very pleasant and inexpensive dressing for use after a hemorrhoidectomy is a large piece of sterile absorbent cotton which may be covered by a large gauze pad. The cotton dressings are used at St. Marks Hospital for Rectal Diseases in London and pack nicely into the anal cleft. Strange as it may seem, the cotton (or "cotton wool" as the English call it) rarely adheres to the cut surfaces. It is, however, difficult to get a large piece of sterile absorbent cotton in many operating rooms. One either has to be satisfied with little cotton balls, or gauze sponges and pads.

Instead of a T-binder, adhesive strips across the buttocks are preferable. As usual there are reasons for the use of adhesive as against the T-binder. With the use of the binder, the dressing often becomes displaced or falls off after the patient returns to his bed. Moreover the dressing, if applied snugly, cuts into the wound and produces pain. On the other hand, adhesive plaster holds the dressing in place, acts as a splint to the buttocks and consequently allows the patient to move as much as he pleases.

## POSTOPERATIVE TREATMENT

It is my custom, if the patient has received an intravenous infusion during operation, to allow the needle to remain in situ, either in the recovery room or in his room to finish up the infusion which has been started. This may be prompted by a desire on my part not to waste the hospital's infusion fluid but it certainly replaces fluid lost through bleeding and through the excessive perspiration we find in postoperative cases. Because of the replacement of fluids by this method, suppression of the urine is minimized and the necessity for the use of the catheter is also partially eliminated. In addition to this, fume-thide iodide, 3 mgm. subcutaneously, is ordered if the patient is unable to void; in fact this may be repeated in 30 to 60 minutes, if necessary. Immediately on returning to the room or recovery room, dramamine, 50 mgm. is ordered by hypodermic to help obviate postoperative nausea. A regular diet is given immediately after operation. This is offered to the patient; who may refuse lunch, but he should be urged to eat at least a part of his dinner. I have done this routinely for over twenty years. Again, as in most of the deviations of proctologists from the old accepted customs in surgery, there are several reasons for the use of a regular diet as soon as the patient returns from surgery. In the first place it does absolutely no harm. Patients will ask "What about my bowels moving?" That also will do no harm. I have had patients occasionally move their bowels during the night after surgery. While this is not recommended, it has not caused any injury and there was no undue discomfort.

We try to have the bowels move, anyhow, forty-eight hours after operation but we may experience difficulty in accomplishing this in many cases. Consequently, low residue diets are taboo. As the second reason for feeding our patients, may I remind the readers that a liquid or low residue diet (especially with considerable milk) in some cases leaves a nasty taste in the mouth; and that frequently this type of diet causes so-called gas pains.

Another result of low caloric diet may be increased nausea due to acidosis from low carbohydrate intake. Dry crackers or toast may help to eliminate the nausea in these cases. Instead of making the first bowel movement more comfortable, a low residue diet results more often than not in a dry hard stool. What we are aiming for is a soft, loose

or semiformed stool which is much less painful to the patient when he first moves his bowels after operation. Trying to get the patient to drink plenty of water after operation also results in softening the stool.

## ENEMAS

Frequently it is necessary to give an enema in order to start the bowels moving postoperatively. Some proctologists order a small oil enema, either to be expelled immediately or to be retained. It is probable that in the former instance a quantity of oil is retained and acts as a retention enema which helps to soften the stool. It is not necessary to use olive oil in this enema—the use of olive oil only increases mounting hospital expenses!

On the other hand, soap suds enemas are rarely if ever used by proctologists. We prefer to treat the mucosa of the bowel as an ophthalmologist treats the conjunctiva and it is very improbable that he would wash out the eye with soap! The old soap suds enema causes cramping. If used before sigmoidoscopic examination, the mucosa will often be injected and inflamed and will give a false picture of the lower intestinal mucous membrane. It is my custom to give the patient an enema of warm normal saline solution postoperatively. An enema of plain tap water or soda bicarbonate, one dram to a pint of water may be used. The temperature of the water should not be over 105 degrees as otherwise severe burning of the mucous membrane may occur. Enemas should never be given through either hard rubber or glass tips, but through a sterile soft rubber catheter (14 to 16 French) which should be well lubricated. It seems absurd to perform an operation under aseptic conditions and then to follow it up two days later by introducing contaminated or at least unsterile enema tubes. Likewise doing a digital examination with the so-called rectal glove instead of a sterile one is not consistent.

It is probable that many fissures which we see after non rectal operations are caused by the careless use of hard enema tips by unskilled nurses or orderlies, and many patients with fissures give a history dating from such time.

There are probably many other points which might be included in a paper of this type, but it is felt that most of the important aspects have been included. Proctologic surgery has a definite place in



the practice of medicine. There are many details in making the patient comfortable; these cannot be found in textbooks or courses in general surgery, nor are they taught to the interns or residents in hospitals having no proctologic service or rectal clinic. In consequence these young physicians come to our midst not knowing modern proctologic procedures, and are unable to learn them in hospitals lacking a proctologic department. It is with this in mind that the methods described above have been discussed.

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## IS OSTEOPATHY STILL A CULT?

THE question expressed in the title of this paper, "Is Osteopathy Still a Cult," merits consideration and open discussion at this time because it was introduced into the deliberations of the House of Delegates of the American Medical Association in June, 1953. Moreover, the House was requested to declare that osteopathy is no longer a cult, and this House, representing the medical profession of the United States, has committed itself to decide this question at its June sessions in 1954. As Doctors of Medicine, as well as members of licensing boards, the constituents of the Federation must have a keen interest in any such decision.

The question posed in the title can be assumed to imply the general opinion held in the past by doctors of medicine, namely, that osteopathy has been a cult, and that if this status has changed materially, this change has not been generally recognized. It is, therefore, the intention of the writer to examine opinions derived from various sources in an effort to clarify the present status of this healing art. In order to do this it first becomes necessary to look into the document that raised this question, namely, Dr. John Cline's report to the House of Delegates of the American Medical Association. In examining this report only factual data will be considered. We will proceed, therefore to this examination.

*Read at the AMA Congress on Medical Education, Chicago, February, 1954*

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## SUMMARY

On the strength of the Cline report to the House of Delegates of the AMA, that body has been asked to declare that osteopathy is no longer a cult. By analysis of the Cline report itself, supported by quotations from recent writings by prominent osteopaths, and from the catalogues of their schools, the author believes he has proved that osteopathy remains a cultist type of healing art.

The first published data bearing on the report mentioned above may be found in the address of President John W. Cline of the American Medical Association, delivered to the House of Delegates of that body in June, 1952. In this address Dr. Cline broached the subject of assistance by doctors of medicine "in further improving the education of students in osteopathic schools." (J. A. M. A. 149:853, June 28, 1952.) In support of this idea he presented the following points:

1. Recent discussions had taken place between a committee from the Board of Trustees of the American Medical Association and a similar group from the American Osteopathic Association.

2. The group representing the A. O. A. had expressed a desire for our assistance in further improving the education of students in schools of osteopathy.

3. We can not recognize the basic concept of osteopathy as a valid method for the treatment of disease.

4. Doctors of osteopathy appreciate this fact and are progressively reducing the emphasis on the teaching of osteopathy in favor of instruction in medicine and surgery.

5. Removal of the stigma of cultism would hasten this process.

President Cline made recommendations based on the points just enumerated. Accordingly a Committee for the Study of the Relations Between Osteopathy and Medicine was appointed with Dr. John Cline as its chairman. Having reported, in due time, to the Board of Trustees, Dr. Cline was asked to read the report of this committee to the House of Delegates. Careful scrutiny of this lengthy report as published (*J. A. M. A.* 152:734, June 20, 1953) indicates that a fairly extensive investigation of osteopathy in all its facets was carried out by the committee. The following salient points are gleaned from this published report:

1. In 1874, when established by Dr. Andrew T. Still, osteopathy "could be classified only as cultist healing."

2. "The earlier schools" followed the dictums of Dr. Still.

3. Since that time "a great evolutionary change has taken place in osteopathy." There being "apparently" no historical account of this change, it is difficult to trace and to document as to time.

4. "Most" of the six existing schools of osteopathy apparently followed Dr. Still's dictums at their beginning, but "at some time all departed from this dogma."

5. "As the evolution of osteopathy has taken place, the concept of osteopathy has changed." The committee found that definitions by various osteopaths were at variance with each other, but "Predominant opinion (amongst those osteopaths who were interviewed) seems to stress that osteopathy encompasses the full field of medicine . . ."

6. "Medicine, as we understand the term, in its various branches probably occupies more than 90 per cent of the instructional hours (in the six osteopathic schools)" and "the total number of clock

hours of instruction in osteopathic schools is on the average about 25 per cent greater than . . . in medical schools."

7. Of the 487 faculty members listed in the six osteopathic schools, 273 have only the degree of D.O. Fifteen have the degree of M.D. The remainder have various other academic degrees. The fifteen doctors of medicine teach in five of the schools. Most of them teach the basic sciences and "some of the M.D. degrees were granted by currently approved schools of medicine."

8. There were 1,921 students in the six schools of osteopathy in 1952.

9. "The Committee had no entirely satisfactory method of evaluating the quality of instruction in clinical subjects" given to 1,921 students by fifteen doctors of medicine, only part of whom received their degrees from currently recognized schools of medicine and most of whom were teaching the basic sciences.

10. The committee was not in a position to evaluate postgraduate training of osteopaths, but noted that in only two states do osteopaths have access to postgraduate course given by state and county medical associations, and "The opportunities for doctors of osteopathy to obtain postgraduate training are meager."

11. The great majority of licensed, practicing osteopaths are to be found in 18 states and more than half of them are in 4 states, namely, California, Missouri, Pennsylvania, and Michigan, and almost 20 per cent being in California.

12. The committee estimated that 6 per cent of the total care of patients in the United States is rendered by osteopaths, yet in another paragraph it is stated that "Public acceptance of osteopathy is extensive."

13. "Instruction in all fields of medicine and surgery has been given in some osteopathic schools for 40 years and formally in all osteopathic schools since 1940."

As a result of the study made by this committee, and based largely on the data presented above, the Committee made several recommendations to the House of Delegates, one of which recommendations is as follows:

"(1) The House of Delegates declare so little of the original concept of osteopathy remains that it does not classify medicine as taught in schools of osteopathy as the teaching of 'cultist' healing."



All interested parties unless it be the osteopaths themselves—doctors of medicine, the courts, the legislatures, and the lexicographers agree with the Committee that osteopathy was cultist healing at its inception. Has there been, then, as the Committee for the Study of Relations Between Osteopathy and Medicine avers but admittedly can not document, a “great evolutionary change” in osteopathy which would compel us to remove it from the category of cultism?

One must admit that individual osteopaths like to practice both osteopathy and medicine. It gives them greater prestige and more remuneration than osteopathy alone. They like to have everyone believe they were taught both osteopathy, and medicine and surgery, because acceptance by the public makes it easier to support the dual personality of practice. Such belief, if established, makes it easier to gain privileges through legislation, and if the osteopath be denied these sought after privileges, by the legislature or by the court, it may make them martyrs in the eyes of the public. This is always a remunerative position in which to find one's self. Some of these considerations may explain why the osteopathic association has seemed less enthusiastic about the AMA declaring them noncultists than has the AMA itself. Such an attitude, however, is beside the point in trying to determine the truth in this matter.

One can find and could quote a great number of statements by osteopaths that not only admit but boast of their cultism during the first twenty-five or thirty years of this century. Not knowing just when the “great evolutionary change” occurred, we are more interested in the last quarter of a century. We will, therefore, consider statements made during this time by a few of the prominent and influential osteopaths. Finally we will turn to the latest catalogues from the six osteopathic schools to learn from them the attitude of the teachers of osteopathy.

In 1935 George M. Laughlin, D.O., then president of the Kirksville school, made the following statement (*Journal of Osteopathy*, February 1935):

“Then again it is the wrong idea for any osteopath to think he is entitled to, or to wish for, unlimited privileges . . . why should an osteopath want to practice medicine anyway even though he were trained in it? Our theory of the cause of disease is entirely inconsistent with the theory of disease from the drug practitioner's standpoint and

our theory of treatment of disease is an entirely different philosophy.”

A statement by the president of the American Osteopathic Association made in the course of his annual address at the 1946 meeting of the Association conveyed the following illuminating words (M. C. Smith, *Nebraska State Med. Jour.*, March 1954):

“There is a growing and marked tendency, and rightly so, to speak of the science of osteopathic medicine as distinguished from allopathic medicine. . . . But woe unto us if we scorn the ladder by which we have arisen, for then we will have thrown away our birthright and cast to the winds that great principle which is our heritage . . . the mechanical basis of health.”

In September, 1952 there appeared an editorial in the *Journal of the American Osteopathic Association* (Vol. 52, page 9) commenting on the conversations between groups from the American Medical Association and the American Osteopathic Association relating to the status of education in schools of osteopathy. This editorial states that these conversations were initiated by the American Medical Association and, in commenting further about the “conversations,” a number of enlightening statements are made. It is suggested that the A. O. A. wishes to cooperate with “any other professional group” in an effort to promote the health of the people, but the following statement quoted from this editorial compels one to believe that the American Osteopathic Association is prepared to resist any change in its philosophy of the cause and treatment of disease: “. . . The American Osteopathic Association reaffirms, in the strongest terms possible, its policy of maintaining a separate, complete and distinctive school of medicine. This reaffirmation is founded in the belief that only as a separate and distinct school of the healing arts can the osteopathic profession fulfill its duty to the public.” This, coming from a leader in the osteopathic profession, printed in the national journal of the association, does not give the impression of a “great evolutionary change” of heart.

These few selected quotations from osteopaths high in their professional organization and their journalism do not seem to indicate a general trend away from the original philosophy of mechanical cause and manipulative treatment of disease. On the other hand, there seems to be a determination to

resist such a trend, whether originated by the AMA, or by some of their own clan. These statements, it is to be noted, cover the period from 1935 to 1952.

Let us now turn to the most recent catalogues, announcements, or bulletins issued by each of the six schools of osteopathy. In reviewing each of these one finds an obvious effort to establish in the mind of the reader, as a fact, the idea that not only osteopathy, but medicine and surgery with instruments, has always been taught in the school. This we know from scrutinizing their earlier catalogues is not true, but time will not permit us to prove it here. On the other hand, each current catalogue, with one exception, makes a frank statement somewhere in its discussion that osteopathy remains true to the principles enunciated by its founder, Andrew T. Still. I shall quote from them, as follows:

Announcement, Chicago College of Osteopathy, 1953-1954.

Page 12. "Emphasis is placed on the study of diagnosis, amplifying the generally employed methods by the interpretation of symptoms in terms of the osteopathic concept." And, on page 25, "It (the instruction in the college) is thorough in its scientific foundations, consistent in its osteopathic viewpoint, comprehensive in its scope and practical in its application."

Announcement, the Philadelphia College of Osteopathy.

On page 26. "Throughout the course the principles and practice of osteopathic manipulative technique are directed to their specified applications in each field."

Announcement, The Kirksville College, for 1952-1953-1954.

On page 11. "It is the primary aim and purpose of the College to preserve, emphasize, and extend in its teaching and research these values, principles, and precepts that distinguish the osteopathic philosophy of the healing arts."

The current catalogue of the Kansas City College

of Osteopathy and Surgery, states, on page 17, "The fundamental purpose of the Kansas City College of Osteopathy and Surgery is to prepare its students for the practice of osteopathy."

The Des Moines Still College of Osteopathy and Surgery states, on page 3, "The Des Moines Still College of Osteopathy and Surgery is dedicated to the advancement of Osteopathic Medicine and Research. This College strives to teach the fundamental tenets of Osteopathic Medicine as stated by Dr. Andrew T. Still."

The quotations recited above, from the current catalogues of five schools of osteopathy, do not support the idea of a "great evolution in osteopathy." One senses only that there is a fairly concerted effort to leave the impression that students in these schools get all that could be given in medical schools with the advantage of osteopathic interpretation and treatment.

More opinion bearing on this subject and supporting the view that osteopathy has not undergone any fundamental change could be presented if time and space allowed. Enough has been set down here to support this contention. As a matter of fact, careful study of the Cline report by uninformed, totally disinterested doctors scarcely needs any supporting evidence to convince them that osteopathy is still a cult.

It is my belief that the report made by Dr. Cline for the Committee for the Study of the Relations Between Osteopathy and Medicine fails to prove that osteopathy is not still a cult, and that the supporting evidence for this point of view as quoted from prominent osteopaths, speaking for the osteopathic organizations, is sufficient to give the strongest support to the conclusion that osteopathy remains a cult. The catalogues of five of the six schools of osteopathy frankly state that the teaching for students adheres to Andrew Still's tenets, though they make a thinly veiled effort to mislead the unwary into believing they also have always taught medicine and surgery as we think of these subjects.



# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### Medical Education for New England

Any thoughtful person interested in medical care in this part of the country should be concerned with the diminishing opportunities for medical education available to the youth of New England. The subject has been approached from many points of view and special commissions have studied it in Maine, Massachusetts and Connecticut. The Massachusetts Legislative Commission is continuing its work and the Connecticut General Assembly of 1953 authorized a new commission to make further investigations, particularly in regard to the possibility of meeting the need with a regional school in which all of the New England States might participate. These two commissions are not concerned with medicine alone but with dentistry and veterinary medicine also; the need in these two professions is quite as pressing as in medicine. There are but two schools of dentistry in New England and no school of veterinary medicine.

The regional school idea has many features to commend it and also some obstacles to its development. The first and greatest of these is to provide the capital and a plant if an entirely new school is to be established. An alternative would be subsidy of existing schools by the states with an agreement that properly qualified students from those states would have priority for admission to the schools. The JOURNAL is pleased to publish a careful analysis of the whole problem by James M. Faulkner, dean of the Medical School at Boston University and Dr. Faulkner's discussion brings intelligent thought to a

question that must ultimately be answered. It is a matter that is more acute for Connecticut than any other of the New England States and will become increasingly so if current population trends continue. It is not generally realized that Connecticut is one of the rapidly growing states of the Union and the most rapidly growing in the East. The population of Connecticut increased 22.9 per cent from 1940 to 1952, comparable figures were Maine 4.3 per cent, New Hampshire 7.3 per cent, Vermont 2.8 per cent, Massachusetts 9.7 per cent and Rhode Island 9.7 per cent. The average for the area was 10.9 per cent. Federal census estimates for 1960 anticipate an increase for Connecticut of 41.4 per cent over 1940 or nearly 20 per cent over 1952. Our population then will be 2,417,000—300,000 more than now. These people will need doctors and from among them there will be more young men and women who will wish to study medicine. Will there be a place for them?

### Detecting Lung Cancer

Within a short time there will be submitted to each and every state and county medical society a proposed lung cancer detection program under the sponsorship of the American Cancer Society and in an effort to comply with the policy of the American Medical Association which believes that such surveys should be conducted at the local level and under the direction of the county or state medical society, the actual work being in the hands of qualified private practitioners. This detection program is based on certain proved facts:

1. There is a real and serious increase in the incidence of lung cancer.

2. There is a silent phase of lung cancer when the lesion is limited to the lung, before there are any symptoms, when the disease can be discovered by routine roentgenograms of the chest.

3. If treated promptly while still in the silent phase, lung cancer usually can be cured.

4. If treatment is delayed for any reason until there are symptoms, probably more than 90 per cent are incurable.

5. The only way at present that lung cancer may be discovered while still asymptomatic and curable is by routine chest roentgenograms.

This program of lung cancer detection was reviewed in detail by a group of physicians representing several of the medical specialties at a meeting in New York City on January 30, 1954. This group is known as the Joint Liaison Committee on Lung Cancer of the American Cancer Society and includes representatives of the chest physicians, thoracic surgeons, radiologists, pathologists, the National Tuberculosis Association, and the American Cancer Society.

Los Angeles County carried out a mass chest x-ray survey in 1951. In this were included 1,867,201 people. Tumor suspects showed up at the rate of 1.9 per 1,000 examined. The unit cost of the survey was \$0.754 per person, making an expense of \$396 to discover each chest tumor suspect. One year later results of the survey led to the conclusions that the mass chest x-ray survey for screening lung neoplasm suspects from the general population is an effective method and that the chest x-ray survey of asymptomatic people appears to be the only way in which asymptomatic, curable cases of lung cancer can be discovered. When it becomes clinically apparent it is usually too late.

The program of taking chest x-rays on every man in the United States who is over 45 years of age is a staggering one in its scope, since there are approximately 25 million men in this category. Thoracic surgeons generally agree that if a lung cancer detection program is to be successful an x-ray must be taken of each man at least once a year and preferably twice a year.

When your local chapter of the American Cancer Society approaches you for your consideration of this cancer detection program you should be pre-

pared to give them an answer. If that answer is in the affirmative you should also be prepared to assist in rendering advice as to the best method of effecting the program.

### Subclinical Sprue

Elsewhere in this issue there appears an article from Madras, India on the subclinical sprue syndrome. Dr. Sarvapalli correctly points out the relative rarity of classical sprue and the comparative frequency of vague abdominal complaints consistent with sprue in its earlier stages. It is our experience in Connecticut, too, that there are significant numbers of adults with mild steatorrhea which responds to folic acid, liver extract, and a high protein, low fat diet. There are also many persons with vague gastrointestinal symptoms totally unrelated to sprue.

There is, however, considerable reason to doubt that what Dr. Sarvapalli refers to as the subclinical sprue syndrome often progresses into classical sprue, even in India. Dr. Sarvapalli states that in his experience untreated cases of the subclinical sprue syndrome develop full blown sprue within a year. If this observation were generally true and the subclinical sprue syndrome were as common as he believes it to be, then unless all the other practitioners in India were as assiduous as he, one would expect classical sprue to be a common entity. Yet he states that the advanced form of the disease is seldom encountered. Dr. Sarvapalli's own evidence suggests that subclinical sprue is often not progressive.

### The Nature of Insurance

Connecticut has been known as an "insurance conscious" state for more than a century. The origins of this state of mind can be found in two places, the inherent sense of thrift and self reliance that has ever been a characteristic of its people and the presence of the great insurance industry in the community. There may be a little bit of pious gambler in the Connecticut Yankee also.

Currently, since Connecticut Medical Service has become such a big and thriving concern, almost every physician in the State feels he is somehow in the insurance business and advice as to how CMS should operate is easy to come by. This is all probably a good thing because it is evidence of a lively



interest in a public development of great concern to the medical profession but as discussion becomes more general there are signs of lack of knowledge of some basic points. Insurance underwriting, even in as relatively new areas as hospital and medical service, has become a nearly exact science and is not simply a playground.

Just a little while ago Mr. James Andrews, Jr., director of Health Insurance for the Life Insurance Association of America, delivered an address before the Tennessee State Medical Association and many things he said would be of value to a similar Connecticut audience. We will quote from it liberally.

"In some ways," Mr. Andrews said, "Health Insurance is a misnomer because insurance cannot make a person more healthy. Nutrition, housing, personal habits, community surroundings and a certain amount of good luck are health producing factors."

From the financial standpoint he said, "Insurance does not lower the total bill of the nation for hospital and medical care" (indeed it might increase it because of increased demand for services), "it merely provides a means whereby the heavier bills, which cannot be met through the individual family's resources, may be pooled with those of other families, thus evening out the risk between participants."

Next, Mr. Andrews presented what he called the "time-worn principles of insurance" and although they related originally to non personal insurance, experience has shown that they are of even more importance in the personal fields.

"First, the hazard insured against must be measurable. It must be clearly defined. If the insured and the company do not know exactly what is being insured, they are both going to be in trouble. For example, medical care in all its complexity has many more variations in definition than a house or automobile."

"Second, the loss insured against should be substantial. There is no point in insuring against routine or very frequent items, each small in itself. To insure these small costs merely means that the insured is paying the company extra money to cover the cost of administering an item which he might pay directly out of his personal budget. Why pay the company \$3 to administer a \$6 claim? If all policy holders do this, the total of \$9 will find its way into the premium calculation, which is the cost to the insured.

"Third, the event insured against should happen

relatively infrequently from the standpoint of the individual insured so that the cost can be distributed over a large group of insureds. If it is fairly certain to happen, the insured person will merely end up trading dollars with other insured persons."

"Fourth, the event insured against should be relatively outside the control of the insured and outside the control of anyone primarily interested in servicing the insured, such as the hospital or the doctor." This is of especial significance in medical service plans and no thoroughly satisfactory means to regulate it has been found other than reliance upon the integrity of physicians and others rendering the service. A method to control it has been the "deductible" type of contract under which the insured pays a part of the cost and Mr. Andrews says, "knowledge by the hospital and the doctor that, for example, 25 cents of each dollar of medical care ordered for the patient will be borne by the patient, will deter ordering of unnecessary medical service." If these unnecessary services should prove substantial, the total claims will spread over the whole group through an ultimate and inevitable increase in premiums.

These observations by an acknowledged expert in health and medical care insurance should serve as a background for all thinking and planning for Connecticut Medical Service. Blue Cross, Blue Shield and private insurance have in a very few years taken a prominent place in the financing of medical care. As time goes on there will be increasing demands from the public and the profession to extend the coverage for subscribers and an alert management should at all times be willing to improve the contracts offered, limited only by the cardinal factors of assurance of the best grade of professional service, the maintenance of financial integrity and a cost to the consumer that will encourage the widest participation.

## Osteopathy

The president of the American Medical Association two years ago, John W. Cline of San Francisco, in an address to the House of Delegates proposed a study of the relationship between regular medicine and osteopathy in order to further improve the education of students in osteopathic schools. A committee was appointed to study this problem and came up with several recommendations to the House of Delegates. One of these recommendations was to

the effect that "the House of Delegates declare so little of the original concept of osteopathy remains that it does not classify medicine as taught in schools of osteopathy as the teaching of 'cultist' healing." Another recommendation would put the stamp of approval on the teaching by regular physicians in osteopathic schools.

As pointed out in a previous issue of the JOURNAL\* by one of our own members, George Blumer, now living in San Francisco, doctors of medicine have been teaching in osteopathic schools for a good many years. Dr. Blumer cites an instance of one of his own former students who became, after graduation from a regular school, professor of anatomy in an osteopathic school.

Mr. M. C. Smith, executive secretary of the Nebraska State Medical Association, addressing the North Central Medical Conference at St. Paul, Minnesota recently discussed "The Osteopathic Problem" and in no uncertain terms condemned any attempt on the part of organized medicine to seek a closer relationship with osteopaths. He argues that "there is no clear cut evidence that the osteopaths have any great desire to have even the stigma of 'cultism' removed," that "they have shown no inclination to have their schools inspected on a basis of medical standards," and that the publicity resulting from the "recognition by the American Medical Association has elevated their standing in the eyes of the public, and has given them a most desirable cloak of respectability."

We are offering in the present issue of the JOURNAL further discussion of this subject under the title "Is Osteopathy Still A Cult?" by George W. Covey, editor of the *Nebraska State Medical Journal*. Dr. Covey analyzes the Cline report and then offers considerable data to show that osteopathy still remains "a cultist type of the healing art."

Your delegates to the coming session of the AMA House of Delegates convening in San Francisco in June will be asked to answer three questions:

1. Should modern osteopathy be classified as "cultist" healing?
2. Since the objectives of the American Medical Association include the improvement in undergraduate and postgraduate medicine, should doctors of medicine teach in osteopathic schools?

\*Editorial, "Regular Medicine and the Cults," XVIII:3, March, 1954.

3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

Members of the Connecticut State Medical Society should give careful thought to this problem. Your delegates wish to represent you and if they do this in a democratic manner they should have an expression of opinion from as many as possible of the doctors back home.

### The Reduction of Blindness

The National Society for the Prevention of Blindness was established forty-six years ago in New York City and is the oldest national organization of its kind. The aims were threefold—educational, preventive services and promotion of research into the causes of blindness. It has a splendid record of accomplishment and is constantly expanding its activities in these fields.

It was founded by Miss Louisa Lee Schyler and Dr. Park Lewis, an ophthalmologist of Buffalo, New York. Their constant contact with the loss of sight due to ophthalmia neonatorum led to the formation of this society in order to curb this tragic situation. At the time of the organization, babies' sore eye accounted for 28 per cent of blindness in schools for blind children. Through the combined efforts of the society, and of medical and lay friends, this figure has now dropped to 2 per cent.

Seven States of the United States have formed state committees under the supervision of the parent organization. Connecticut was the most recent State to have formed a committee, doing so in April 1953. The Connecticut group has a large committee of interested and active lay members as well as ophthalmologists and optometrists. They are backed up by the National Society with the assistance of its able and excellent staff members.

The chairman of the Connecticut Committee is Mr. Stanley F. Withe of Hartford. It is ardently hoped that with the formation of this State Committee much can be accomplished in the matter of research into the causes of blindness, more thorough care of the eyes of children and the prevention of accidents at all ages.

The number of blind people in the United States is estimated to be 316,000 with an additional 25,000 with visual acuity reduced to 20/200 or less. The cost of adequate care of the blind is stated to be



\$150,000,000 a year and yet the amount of money available for research into the causes of blindness was but \$1,700,000 last year—a pitifully small amount when one considers the funds raised for the study and treatment of numerous other disabling and destructive diseases. Many of the pathological processes for which large sums are contributed end fatally, whereas blindness in itself never causes death and persists for the balance of life. For humanitarian and economic reasons, greater sums of money are needed for research into the causes of blindness.

Such projects as screening of the eyes of school children, detection of trachoma in some parts of the country, research into the etiology of such major causes of blindness as glaucoma, cataract and uveitis are all fostered by the National Society and will be by the Connecticut Committee. Several glaucoma clinics have been formed for the study and treatment of this baffling disease, which accounts for 12 per cent of all blindness. A case-finding study to determine how much unrecognized glaucoma exists was recently done in Philadelphia. Four thousand people, 40 years of age or older, employees of department stores and insurance offices were screened. These people had no complaint of ocular disease but 76 cases of unrecognized glaucoma were found, that is 2 per cent.

Ten per cent of blindness is caused by accidents in children and adults. Half of this is easily preventable. Sixty Americans become blind each day—22,000 a year. These are starting figures and challenge our best efforts to correct them so far as is possible.

Some noteworthy achievements are deserving of attention: among children, there has been a drop of 54 per cent blindness due to venereal disease—especially syphilis since 1936, a 96 per cent reduction in blindness from babies' sore eyes since 1908, and a 30 per cent decrease during the past fourteen years in blindness due to injuries. Public education can make the average citizen realize that apparently trivial symptoms may mean severe trouble with the eyes and the American public is eager for information on diseases. An important function of a voluntary health organization is to present authentic information on all such subjects.

One of the more recent projects of the society is the sponsoring of the Wise Owl Clubs, the first of which was first organized by The American Car and Foundry Company at the suggestion of one of its employees. A workman becomes eligible to member-

ship in the club if he has prevented an injury to his eyes by wearing proper protective glasses. A ceremony is made of the presentation of a certificate of membership in the Wise Owl Club and a gold owl lapel button is awarded. The American Car Company turned over this plan to the National Society and within six years the number of clubs has reached several hundred and there are now more than 5,000 members, who, but for wearing protective equipment, would probably have lost one or both eyes. In the prevention of blindness from accidents lies one of the greatest opportunities.

In recent years there has been a constantly increasing number of appeals to the people of America for support of research into the causes and for the care and treatment of numerous disease conditions. The response has been remarkable and is an evidence of the humanitarian spirit of our people. Those who are particularly interested in the preservation of good vision and in research into the causes and prevention of blindness have not presented the case with sufficient vigor and realism so that the support of their project has lagged far behind other worthy appeals. For this reason, we beg to present their case for the organizations devoted to that purpose. Aid as well as sympathy is needed to ward off the most dreaded affliction, described by the poet, John Milton, as

"One fallen on evil days,

In darkness, and with danger compassed round,  
and solitude."

### Social Security for the Physician

Many of our readers have asked: "Why is it not to our advantage to be included under the provisions of the Social Security laws?" Many others, particularly of the younger group, have expressed a preference for such inclusion as permitted in the Reed bill rather than lending support to the Jenkins-Keogh bill which allows the establishment of a retirement fund.

The American Medical Association and the American Bar Association have openly opposed compulsory inclusion of self employed professionals under Social Security laws. The explanation for this attitude has been expressed briefly and lucidly by one of Connecticut's prominent attorneys. The JOURNAL is privileged to publish this statement together with concrete explanatory figures in this issue. Although there seems to be little hope of passage of the Jen-

kins-Keogh bill in this Congress, there is considerable likelihood that it may pass the next Congress if self employed professionals express themselves sufficiently forcefully in favor of such legislation.

Seventy-Five Years of Accomplishment

Few are the physicians in Connecticut who remember when the General Assembly in March 1878 passed an act establishing the State Board of Health. The original act called for the appointment by the Governor "by and with the advice and consent of the Senate" six persons, "three of whom shall always be physicians and one lawyer who together with a secretary to be elected by them shall constitute the State Board of Health."

This department is now 75 years old. During this period of time the changes and developments have been little short of amazing. The number of licensed physicians in Connecticut in the last 31 years alone has more than tripled. From one full time health department in New Haven in 1873 we now find 15 communities in the State which provide full time health services under full time directors of health. The general death rate has dropped from 15.4 per 100,000 population in 1878 to 9.5 in 1953. The maternal mortality rate has seen a constant downward trend to 0.2 deaths per 1,000 live births in 1952. The common drinking cup was abolished by law in 1912 and the following year saw the establishment of the first chlorination plant in the State. In 1935 Connecticut was the first State to pass a law requiring premarital blood tests for syphilis; six years later the prenatal blood test law went into effect. These are but a few of the many progressive steps for which the State Department of Health has been largely responsible.

Stanley H. Osborn came to Hartford as State Commissioner of Health in 1922. Connecticut citizens owe Dr. Osborn an immeasurable debt of gratitude for 32 years of devoted service to the cause of humanity. Unswerving in his devotion to duty, his has always been a progressive and far seeing approach to the problems of health as they have developed in a changing world. With him on the Public Health Council two physicians are still serving, George H. Gildersleeve of Norwich, immediate past president of the State Medical Society who has served for 15 years, and W. Bradford Walker of Cornwall, a member of the Council for seven years.

THE CONNECTICUT STATE MEDICAL JOURNAL offers

its hearty congratulations to the State Department of Health, Commissioner Osborn and his entire staff.

Cancer of Lungs in Norway

According to a report from Norway in the *Journal of the American Medical Association* (154:10, March 6, 1954), cancer of the lungs is the fourth most common form of cancer in that country. Less than six per cent of all the deaths from malignant disease in men in Norway are due to this disease while the corresponding rate in Great Britain is 25 per cent. Another interesting fact is that not quite half the Norwegian patients with cancer of the lungs have had a history tending to incriminate smoking.

Dr. Elliott Sweet Awarded Fellowship

Elliott B. Sweet, son of the late John H. T. Sweet, a well known and highly respected orthopedic surgeon of Hartford, has been awarded a research fellowship in hip surgery at the Massachusetts General Hospital. This fellowship has been made possible by a gift from the radio and TV star, Arthur Godfrey.

Dr. Sweet represents the seventh generation of orthopedic doctors in his family, was educated at Loomis Institute, Dartmouth College, and the University of Virginia School of Medicine, and obtained his internship at Hartford Hospital followed by a residency at the Massachusetts General Hospital. He holds the questionable distinction of having been shot down and held as a prisoner of war for six months while serving as a navigator in the 15th U. S. Air Force, stationed in Italy.

THE DOCTOR'S OFFICE

Charles A. Crown, M.D. announces the opening of an office for the practice of internal medicine at 39 South Avenue, New Canaan.

Anthony Kominos, M.D. announces the opening of an office for the general practice of medicine at 1274 Summer Street, Stamford.

Archy W. Lewandrowski, M.D. announces the opening of an office for the practice of internal medicine at 295 Long Hill Road, Groton.



## PROGRESS IN CLINICAL MEDICINE

### AN EXPERIENCE WITH $I_{131}$ IN CARDIAC DISEASE

#### A Preliminary Report from the Isotope Committee of the New Britain General Hospital

ON August 5, 1949 the Atomic Energy Commission approved the application of the Isotope Committee of the New Britain General Hospital to receive and dispense radioactive isotopes. Approval for the use of radioactive materials in a community hospital depended then, as it does today, upon the availability of personnel qualified to handle the materials safely, to measure its activity reliably and to observe and record its use. Dr. John C. Larkin, radiologist of the hospital, undertook the job of sorting, measuring and dispensing the materials and, with the cooperation of the Committee, of making it available to the physicians of the hospital. During the period of nearly five years of the work at the New Britain General Hospital, radioactive iodine has been used for diagnostic and therapeutic purposes on 234 patients. This, of course, is a small experience compared with that of many institutions. It represents, nevertheless, a significant endeavor on the part of the staff of a community hospital and in that respect we believe it deserves to be reported.

The technical problems incident to handling isotopes were met through the efforts of Dr. Larkin to set up a laboratory and essential equipment in an area adjacent to the hospital. During the first year the measurement of the activity of the iodine samples and the concentration of the materials in the thyroid glands of tested and treated patients was made by an ionization chamber. This type of apparatus required relatively large doses for tracer studies and after the first year a Geiger Muller counter was made available through a grant from the New Britain Heart Association. This permitted the use of tracer doses of 50 microcuries and more accurate determination of activity in the gland. Since September, 1953 the effective tracer dose has been reduced to 10 microcuries because of the purchase of a scintillation counter. It is emphasized that each of these measuring instruments requires some special precaution to

insure the accurate estimation of the activity of the iodine samples, both before and after its absorption in the gland of the tested patient. This situation obtains in employing the highly sensitive scintillation counter as well as in the use of the ionization chamber.

Interest was shown at once by physicians of the New Britain General Hospital in the diagnostic and therapeutic opportunity presented by the availability of  $I_{131}$ . They were encouraged to present patients for tracer studies and, in suitable cases, for treatment. It is believed to be of sufficient importance to relate briefly the experience of the Committee in the selection of patients. Each physician was obliged to present evidence of the clinical condition of his patient in an application for the use of the isotope. The decision to treat the patient rested upon his judgment, the results of the uptake test, and finally upon the approval of the radiologist. The Isotope Committee acted in an advisory capacity. It rapidly became apparent that the follow-up of the patients treated was far from complete or reliable. The selection of the patient by the referring physicians proved to be insufficiently critical, and a change in procedure was instituted. Thereafter the physicians of the Isotope Committee, with the cooperation of the referring physician, undertook to select appropriate patients for treatment, to choose dosage, to examine patients before and after treatment, to require additional studies, and to attempt evaluation of the course of the patient. During the past three years the Committee has found itself repeatedly in need of re-examining its procedures, of altering its criteria in the selection of patients and the means of judging results. It is well to point out that during the years of this effort there has been a remarkable amplification of the knowledge of the use of  $I_{131}$  because of multitudes of reports from other clinics.

The Isotope Committee recognizes that fairly

definite criteria have been evolved for its guidance in the use of I<sup>131</sup> in the treatment of patients with disorders of the thyroid gland. So far as possible it has adhered to these criteria. It has no experience in the treatment of patients with known or suspected malignant disease. While it has attempted only to follow the standards generally accepted for treating thyroid disease from the earliest days of its work, the Committee has been interested in and to some extent has set its own principles to work in the treatment of patients with disability due to cardiovascular disease.

It is general experience that when patients have symptoms producing heart disease and the additional burden of an overactive thyroid, reduction of the thyroid activity gives gratifying results. The Isotope Committee has had satisfactory experience in treating thyrocardiacs with radioactive iodine. It is aware that physicians are, in general, aware of the good results which may be expected in the treatment of thyrocardiacs, and alert to the possibility of so-called masked hyperthyroidism. Nevertheless, the Committee has on several occasions discovered patients who were assumed to be euthyroid, but who were investigated with a view to trying to mitigate their congestive failure, and found to have significant evidence of hyperactivity of the thyroid gland. The following case summary will illustrate this point.

M. C., a 46 year old housewife, had been under observation for fifteen years because of rheumatic heart disease, aortic and mitral valvular disease, and hypertension. Her thyroid gland was not palpable nor evident by x-ray. Late in 1951 she had developed auricular fibrillation and evidence of congestive failure for which she had received conventional treatment. In February, 1952 her condition had advanced to the point where she had to give up her employment as a seamstress and lead a very restricted life. A BMR of plus 49 was obtained, and on March 14, 1952, 62 per cent of a 50 microcurie trace dose was found in the gland after 24 hours. Two doses of 5 millicuries of radioactive iodine resulted in a fall in the uptake to 28 per cent and a lowering of the basal rate to plus 6. Without other change in her management the patient recovered her well being, lost her congestion, and was able to return to work. In this instance one contribution of the Isotope Committee was to the effect that physician suspicion of masked hyperthyroidism was increased.

The Committee has been made increasingly aware of the difficulty of distinguishing clinically between patients with hyperthyroidism and those with clinical states which resemble hyperthyroidism. This difficulty is especially apparent in patients with tachycardia and hypertension, and in patients with

congestive heart failure. In such situations the basal metabolism is likely to be misleading. Reliable estimations of the protein-bound iodine have not been generally available to patients in this hospital. The result of tracer doses of iodine has been the primary criteria upon which the Committee has depended. When the results of tracer studies have been easy to classify, the judgment is readily made; in cardiacs with tracer results that are slightly elevated, the Committee has leaned to the side of treating the patient rather than not treating him.

For nearly five years the Committee has undertaken to treat patients who appear to be euthyroid, both by clinical evidence and tracer studies, who have angina pectoris as their principal complaint. Up to this time 12 such patients have been treated and followed, two of these having concomitant congestive failure. The Committee has been encouraged by its experience with this small number, but is dismayed by the difficulties which arise in the evaluation of its results. Patients are gratified by the interest and attention which they receive and may be inclined to give favorable reports. It has been the policy of the Committee to limit the size of the treatment doses to such an amount as will not be expected to produce frank myxedema. It is likely to give 10 to 15 millicuries at a time, to be repeated if necessary.

S. H., a 58 year old white male, is classified by the Committee as euthyroid (BMR minus 10), with no palpable gland, and with arteriosclerotic heart disease. He has had one myocardial infarction. He had been hypertensive but in October, 1952, at the time of his tracer dose, had a blood pressure of 120/100. He was limited in his activity by angina and using three or four pills of nitroglycerine daily. He was found to have an uptake of 20 per cent and was given an initial dose of 15 millicuries and a repeat dose two months later of 5 millicuries. Subsequent interviews reveal that he has increased his activities, that he is free of pain and not in need of nitroglycerine.

In spite of the example of such a patient, it is acknowledged that the natural course of patients with angina pectoris is notably variable. Time and a much more extensive experience will be necessary before any judgment can be made here about the value of treatment of this disorder.

We have likewise been both encouraged and discouraged in our treatment of patients with congestive failure. Nine patients with seemingly intractable failure have been followed after treatment. A rough objective measure of improvement has been the greater freedom from the dependence upon mercurial diuretics and lessened need for frequent



removal of hydrothorax. Although it is doubtful that this experience will ever result in a series of cases which will convince others of demonstrated benefit from treatment, it is the intention of the Committee to continue to offer to patients with congestive failure, who have been observed carefully and at length, the possible help from doses of  $I_{131}$  calculated to reduce their thyroid activity.

### Highway Accident Toll 95,000

1953 accidents: killed 95,000; injured 9,600,000; cost \$9,100,000,000.

1953 death toll was 1,000 below 1952 total but more than three times as great as entire number of Americans killed in Korean war.

The motor vehicle held its place as the No. 1 accident killer. Traffic deaths numbered 38,300. That was a gain of 300 or 1 per cent over 1952.

The traffic total was the third largest in history, exceeded only in 1937 and 1941.

Fatalities in home accidents numbered 28,000, a decline of 1,000. Accidental deaths at work were unchanged at 15,000.

There were some relatively bright spots in the otherwise grim array of statistics.

The 1953 death rate for accidents of all types was 60 per 100,000 population. That was the lowest on record.

Nevertheless, one out of every 16 persons in the United States suffered a disabling injury last year.

The 38,300 traffic deaths were recorded during a year when the number of vehicles on the road and the number of miles they traveled reached an all time high.

Thus, the death rate per 100 million vehicle miles was estimated at 7—the lowest rate on record.

Traffic accidents resulted in about 1,350,000 non fatal injuries

Falls brought death to 20,200 persons, 1 per cent fewer than in 1952. Burns cost 6,400 lives, a 4 per cent decrease. Firearms fatalities rose 4 per cent to 2,450. Drownings were unchanged at 6,800.

Accidental deaths showed an increase among the new generation—victims 5 to 24 years old. There was no change in the 25 to 44 age bracket. Decreases were shown for children under 5 and adults over 45.

The estimated economic loss of \$9,100,000,000 covers both fatal and nonfatal accidents. It includes wage losses, medical expenses, insurance costs, production delays, damage to equipment and property.

Last year ended with traffic deaths on the upswing. The December total was 3,930. That was 6 per cent higher than in December 1952.

Seventeen states showed a reduction in traffic deaths for 1953. Connecticut was not one of the 17, in fact no New England State showed any reduction in number of traffic fatalities.

### Catholic Physicians Guild Formed

The first formal meeting of the Catholic Physicians Guild of New Haven was held on October 18, 1953 at St. Raphael's Hospital. About fifty physicians attended. Michael S. Shea was elected president, Charles T. Flynn, vice-president, and Henry S. Milone, secretary-treasurer. The executive committee chosen consisted of William H. Ryder, Mario L. Garafola and William D. Riordan.

Archbishop Henry J. O'Brien has given his approval for the organization to affiliate with the National Federation of Catholic Physicians Guild. Father John C. Knott was appointed chaplain of the group.

The group meets monthly for discussion of topics, the moral aspects of which are of vital interest to physicians.

On the agenda for future discussion meetings are such topics as birth control, marriage counselling by priest and doctor, and the moral obligation of doctor toward patient. Another topic to be considered is the ordinary and extraordinary means of treatment of patients. The principles involved in abortion, sterilization and mutilation operations will also be discussed.

True to its aims of association, Catholic principles in the practice of medicine, the Guild continues today as it was organized—based on purely medical and moral ideals rather than on social or political ideas. To counteract the materialism and secularism of today's world, the doctors feel that such an organization is needed from a strictly moral standpoint.

Plans for the future are very closely united with one of the factors that brought the small group of doctors together in the first place, viz., prepared talks for church groups.

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## THE SECRETARY'S OFFICE

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### COUNCIL MEETING

The regular monthly meeting of the Council was held at the offices of the Society on April 7, 1954. The meeting was called to order by the Chairman, Dr. Danaher, at 4:30 P. M. There were present in addition to Dr. Danaher, Drs. Gildersleeve, Marvin, Couch, Barker, Weld, Whalen, Fincke, Gallivan, Walker, Gettings, Labensky. Speaker of the House Dr. Gibson, Vice-Speaker Dr. Feeney, Alternate Councilors Gens, Ogden, Buckley, Archambault, Gilman. Absent: Drs. Murdock, Tracy, Flaherty, Ottenheimer, Ursone, Otis.

#### BY-LAW REVISION

The Chairman, Dr. Danaher reporting in regard to the appointment of a subcommittee of the Council to propose By-law and Charter Revisions relating to Alternate Councilors, the Speaker and Vice-Speaker of the House of Delegates, stated that he wished to postpone the appointment of the committee until after the Annual Meeting of the House of Delegates because it was understood that there would be changes in the make-up of the Council due to the election of new Councilors from certain counties.

#### REFUND OF DUES

Dr. Couch, the treasurer, presented the following proposals concerning the refund of dues of members who become exempt from dues payment during a year. (See Council Minutes, Item No. 13, March 11, 1954.)

"When a member of the Society is exempt from payment of dues, as provided in Article IX, Sec. 1, Pars. 3 and 4 and he has paid his dues for the current year prior to such exemption, the treasurer of the State Society shall refund to him the amount of dues paid to the Society for that year. At the same time the treasurer shall notify the secretary (or treasurer) of the County Association, to which the member belongs, that the refund has been made, so that refund of county dues may be made by the County Association also.

"A member exempt from a payment of dues because of entry into the military service or entry into

a full-time approved educational program shall be exempt from the payment of dues for the year in which he enters military service or an educational program and for the year in which he terminates such service or program. If required, appropriate refunds will be made by the treasurer of the State Society."

It was voted to adopt these proposals and make them effective from this date.

#### FEDERAL COMMISSION ON INTERGOVERNMENTAL RELATIONS

A questionnaire on behalf of the Federal Commission on Intergovernmental Relations was presented and discussed (see item No. 12, Council Minutes January 14, 1954). It was voted that the questionnaire be referred to the Committee on Public Health with a request that the Committee provide answers to the questions included and submit its opinions to the Council for consideration at its next meeting in May. (AMB 4/7/54 "B".)

#### AMA COMMITTEE ON INTERN TRAINING

A request from the American Medical Association for action and opinions of the Society in relation to intern training and internship approval was presented. (AMB 4/7/54 "C".) This information was sought for a Committee on Internship of the House of Delegates of the American Medical Association, appointed in compliance with a resolution of the House at the annual session in June 1953. The fol-



lowing is a question from the work plan of the committee:

"Many of the present problems involving internship stem from the discrepancy between the number of internships offered in approved hospitals and the number of available applicants. As a result, hospitals, particularly those of smaller size and without medical school affiliation, have had difficulty in filling their house staff requirements. It is anticipated that the committee will give consideration to this and related problems."

It was voted that this matter be referred to the Society's Committee on Medical Education and Licensure with the request that a statement of its opinion be given to the Council with the least possible delay so that it can be forwarded to the American Medical Association Committee.

#### SAMA AT YALE

The secretary presented a report from Dr. Morris P. Pitock, chairman of the Society's Committee on Student Membership relating to efforts to organize a Chapter of the Student AMA at the Yale Medical School. (AMB 4/7/54 "D".)

#### ETHICS OF BILLING BY PHYSICIANS

Correspondence and a questionnaire from the American Medical Association relating to changes in Principles of Medical Ethics of the AMA were presented and discussed at length. (AMB 4/7/54 "E.") The secretary was finally directed to answer the questionnaire and actual working decisions in this connection in the House of Delegates of the American Medical Association was left to the Society's delegates.

#### CONNECTICUT ADVISORY COUNCIL ON SCHOOL HEALTH

A report from Dr. Robert R. Keeney, Jr., chairman of the Society's Committee on Public Health, stating that the Connecticut Advisory Council on School Health had been organized, (see Item No. 9, Council Minutes, November 9, 1953) was presented. Dr. Gildersleeve reported that he had on request of Mr. Finis Engleman, commissioner of education, appointed Dr. Charles A. Murphy of Stamford and Dr. Joseph L. Hetzel of Waterbury to represent the society on this Council. This action of Dr. Gildersleeve was approved.

#### SCHOLARSHIP WINNERS AT ANNUAL DINNER

It was voted that the society would invite to the Annual Dinner on April 28 the three medical students who received the Society's scholarships in 1953 and also pay their necessary travel expenses for their journey to New Haven.

#### KARL T. PHILLIPS

Dr. Weld reported concerning the serious accident that Dr. Karl T. Phillips, a former member of the Council, had been involved in lately. Dr. Phillips is recovering slowly, but it is doubtful if he will be able to engage in any occupation for some time. It was voted that the secretary should write Dr. Phillips a note of condolence from the Council.

#### LEAVING THE COUNCIL

It was noted that this meeting ended the services on the Council of Edward J. Whalen, Hartford, councilor-at-large; James A. Gettings, New Haven, councilor from New Haven County and Ralph T. Ogden, Hartford, councilor from Hartford County.

#### ANNUAL MEETING

It was voted that the Annual Meeting of the Council be held on May 13.

#### DEAN EBBERT GUEST

Meeting adjourned at 6:15 P. M. following which the gentlemen of the Council dined at the Graduate Club. Dr. Arthur Ebbert, Jr., assistant dean Yale School of Medicine was a guest of the Council.

### Meetings Held During April

- April 6—Committee on State Blood Bank
- April 7—Council Meeting  
Committee on Toxemia
- April 8—Committee on Public Health
- April 19—Joint Committee on Psychiatric Service in General Hospital
- April 23—Surgical Section, Clinical Congress Program
- April 27—Annual Meeting of House of Delegates
- April 28—Annual Meeting of Society  
and 29 Annual Meeting of Society

## New Members

### NEW HAVEN COUNTY

Charles H. Audet, Jr., Waterbury  
 Robert J. Audet, Waterbury  
 Eugenia S. Cameron, New Haven  
 John F. Cohane, New Haven  
 Cyula I. deSuto-Nagy, New Haven  
 William N. Dickinsen, Yalesville  
 Arthur Ebbert, Jr., New Haven  
 Franklin H. Epstein, New Haven  
 Stephen Fleck, New Haven  
 Morris Green, New Haven  
 Mark A. Hayes, New Haven  
 John W. Higgins, New Haven  
 Francis L. Ilg, New Haven  
 Edward T. Johnson, Meriden  
 David J. Kreis, New Haven  
 Charles L. Larkin, Waterbury  
 Andrew J. Laudano, New Haven  
 John J. Mead, III, New Haven  
 Ray E. Persons, Meriden  
 Francis O. Pfaff, New Haven  
 Anson G. Stocking, Waterbury  
 Martin L. Sumner, Waterbury  
 Maurice B. Thompson, West Haven  
 Frederick H. Treder, New Haven  
 Vita Vileisis, Waterbury  
 Andrew S. Wong, New Haven

### NEW LONDON COUNTY

Desmond G. Boyle, Norwich  
 Lewis F. Cole, New London  
 Norman L. Cressy, Norwich  
 Paul J. Gerity, New London  
 James A. Harkins, Norwich  
 William A. Kramm, Niantic

### HARTFORD COUNTY

Fred C. Barald, Hartford  
 Hester B. Curtis, Hartford  
 Geza O. Benkovich, New Britain  
 Anderson W. Donan, Simsbury  
 E. Cecil Eagan, Hartford  
 Frank R. L. Egloff, Hartford  
 Donald S. Hauss, Hartford  
 Wesley W. Holden, Bristol  
 John J. Houlihan, Hartford  
 Walter P. Kosar, Hartford  
 Alexander Menzer, Hartford  
 Stanley J. Motyka, New Britain  
 Ralph F. Reinfrank, East Hartford

Gordeon B. Wheeler, East Hartford  
 G. Montgomery Winship, New Britain  
 Richmond C. Hubbard, Hartford  
 Charles P. LeRoy, Jr., Hartford  
 Gerald V. Levreault, Hartford  
 Edward R. Owens, Hartford  
 Philip R. Partington, Hartford  
 George F. Parton, Jr., Hartford

### MIDDLESEX COUNTY

Charles E. Meredith, Middletown  
 John Stanford, Essex  
 Andrew Turano, New York  
 Leon J. Yorburg, Durham

## Doctors, Dentists and Lawyers Meet

On March 24 the Conference Committee with the Connecticut State Bar Association and the Conference Committee with the Connecticut State Dental Association met at the Lawn Club in New Haven to discuss present legislation before Congress. There were present from the State Medical Society Edward T. Wakeman of New Haven, David J. Cohen of Meriden, Cornelius S. Conklin of Bridgeport, Camille H. Huvelle of Torrington, George H. Gildersleeve of Norwich, President H. M. Marvin of New Haven, Sidney Shindell of Rocky Hill, Creighton Barker of New Haven, Stanley B. Weld of Hartford, and James G. Burch, director of Public Relations.

From the State Bar Association were present Julius B. Kuriansky of Stamford, Herbert McDonald, president, and David Richman, both of New Haven.

From the State Dental Association were Henry T. Quinn of Greenwich, E. S. Arnold of West Hartford, and Philip M. Chernoff of Middletown, president.

Dr. Gildersleeve presided and Dr. Cyrus Maxwell of the AMA Washington office discussed various bills affecting the professions represented and now before Congress. The most lively discussion centered around the Jenkins-Keogh bills and HR7199, the administration bill for extending social security coverage. It was ably pointed out by Attorney Richman that much of the expected financial benefits for the professional man to be derived from the latter bill, if enacted, were so nebulous as to be of little value.



The concensus of opinion of all three groups represented was to the effect that security for the professional man could be better attained by passage of the Jenkins-Keogh bills. These bills provide that self employed and pensionless employed persons would be permitted to set aside, tax free, a limited portion of their earned incomes into individual retirement funds; taxes will be paid upon the withdrawal (usually as pensions) of these funds. The result would be tax deferment similar to that on employers' contributions to tax-exempt plans approved by the Bureau of Internal Revenue under Section 165 (a).

### Connecticut Committee on Foods, Drugs, Cosmetics and Devices: Meeting of February 4, 1954

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Mr. Felix Blanc, representing the Pharmacy Commission; Dr. Barnett Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

#### "VETERINARY USE" DRUGS

There was considerable general discussion of this topic, but no action was taken by the Committee. Dr. DeVita said that the veterinarians were considering proposing that mastitis remedies, as well as estrogens designed to be implanted into poultry, be required to be dyed. He said that Canada prohibited the use of estrogens in poultry, and in South America there had been claims that eating "caponettes" could produce cancer. If the mastitis preparation were dyed, milk from udders in which they were used would not be drunk.

An official Food and Drug Commission sample of a "Veterinary Penicillin Dihydro-Streptomycin

Ointment" put out by Farmers Veterinary Distributors, P. O. Box 442, New London, Connecticut, was displayed by Mr. Plank. This product was enclosed in a carton labelled only with a "No. 14" and the statement "Tested & Certified by U. S. Food & Drug Dept." Mr. Plank called the members' attention to the fact that not only was such a claim obviously false, but the law specifically forbade reference to acceptance by an official agency.

Dr. DeVita noted that drugstores must be licensed, while grain stores could handle penicillin and other dangerous drugs (including strychnine) without licensing. He said the veterinarians were studying this problem with the intent of devising a practical remedy.

Mr. Plank said that, when the sulfa drug question came up some years ago, some poultry producers in the northeastern section of the State had claimed that they could get these drugs in sufficient quantity only from grain stores. The present Federal ruling was that any drug other than those for intravenous injection could be sold over the counter if marked "For Veterinary Use" and accompanied by directions for use.

Prof. Fenney remarked that the question boiled down to devising some way of ensuring that these veterinary preparations would be used as intended and not be diverted to human use.

#### "DRY-TABS"

Mr. Plank passed around a sample of a product of the above name, manufactured by Gary Pharmaceutical Company, 7508 Saginaw Avenue, Chicago 49, Illinois. The label described the "Dry-Tabs" as "An aid to help curb functional Bedwetting when due to emotional or nervous tension or habit only," and stated the active ingredient to be  $\frac{3}{8}$  grain ephedrine sulphate per tablet. The 21-tablet plastic vial sold for \$3.

Mr. Plank asked the Committee's opinion on whether these tablets would work and whether they were safe. The members all felt the "Dry-Tabs" were ineffectual and not the best treatment, but that it would be hard to substantiate this belief.

It was voted that the secretary be directed to write the Connecticut pediatricians' group and ask their opinion on "Dry-Tabs."

#### THE ASSMAR HICCUP-CURING MACHINE

Mr. Plank submitted a newspaper article concerning this device, and remarked that the man who

invented it was over a doctor's office and he understood the doctor recommended it. Dr. Hart added that he understood there was no fee involved.

It was voted that a subcommittee composed of Dr. Hart (chairman), Dr. Greenhouse and Dr. Wedberg be appointed to look into this question and report to the next meeting.

"DELICATE"

Mr. Plank showed the members a sample of this product, which is composed of an extremely small package into which is compressed a sanitary napkin and belt.

### Education in Polio Care

During the week of April 5 an institute on the nursing care of the poliomyelitis patient was held at the Hartford Hospital under the auspices of the Division of Nursing Services of the Connecticut League for Nursing in cooperation with the Connecticut State Medical Society, the Connecticut Hospital Association, and the Hartford Chapter of the National Foundation for Infantile Paralysis. Miss Mary E. Brackett, R.N., associate director of nursing service at the Hartford Hospital, was general chairman for the Institute. The purpose of the Institute was to educate nurses in modern methods of polio care in preparation for the acceptance of acute and convalescent poliomyelitis cases in general hospitals.

Forty-six nurses enrolled in this Institute. They represented Hartford Hospital, Grace-New Haven Hospital, Mt. Sinai Hospital, St. Francis Hospital, Sharon Hospital, Johnson Memorial Hospital in Stafford Springs, Manchester Memorial Hospital, Middlesex Memorial Hospital in Middletown, Charlotte Hungerford Hospital in Torrington, New Britain General Hospital, Bristol Hospital, St. Mary's Hospital in Waterbury, Bradley Memorial Hospital of Southington, Meriden Hospital and Lawrence Memorial Hospital in New London.

At the opening session the first evening more than 125 medical officials from the northern half of Connecticut discussed the care of polio patients.

Dr. James C. Hart, director of the Bureau of Preventable Disease in the Connecticut State Department of Health, reported that of the 335 polio cases handled by Connecticut hospitals in 1953, 149 were handled by the McCook Hospital. Grace-New Haven Hospital had 34, Norwalk Hospital 30, Waterbury Hospital 24, Englewood Hospital 18,

Bridgeport Hospital 13, Stamford Hospital 13, Mitchell Isolation Hospital 12, St. Mary's Hospital 7, and Hartford Hospital 5. The remaining cases were spread over 18 other hospitals.

The evolution of isolation hospitals from the pest houses of the Middle Ages to the present day where they are being incorporated in the wards of general hospitals was described by Dr. Alfred L. Burgdorf, moderator of the meeting and director of health in Hartford.

Richard West, superintendent of the Norwalk Hospital, and Miss Lillian Reiners, R.N., director of nursing for Norwalk Hospital, outlined procedure for caring for polio patients in their hospital. They said when they began admitting polio patients nearly seven years ago they had to start off by selling the idea to their medical and nursing staffs. Then they had to train the personnel. They now feel that, through their program of caring for Norwalk's polio patients, they are discharging a community responsibility. They said the assumption of this responsibility has developed good public relations for the hospital.

Assisting Miss Brackett, general chairman of the Institute, was Miss Marie Kennedy, R.N., Newington Home and Hospital for Crippled Children as chairman of the nurse faculty. Faculty members were Miss Doris Langdon, R.N., State Department of Health; Miss Freda Pongratz, R.N., St. Francis Hospital School of Nursing clinical instructor; Miss Katherine Davis, R.N., administrative supervisor of children's nursing service, Grace-New Haven Hospital; Miss Sarah C. Johnson, physical therapist, Connecticut State Department of Health, and Miss Francis Tappen, technical director, University of Connecticut School of Physical Therapy; and a representative of the Nurse Advisory service for orthopedics and poliomyelitis of the National League for Nursing.

During the sessions the following physicians participated: Wilson F. Smith, who spoke on "General Medical Care of Acute Poliomyelitis;" Carl Hellijas, "The Mechanics of Respiration;" Frank Jones, "Orthopedic Care During Convalescent and Reconstructive Stages;" John C. Allen, "Physical Medicine Responsibilities and Orthopedic Appliances;" and James C. Fox on "Psychological Aspects of Polio From Standpoint of Patient, Family and Nurse."

A tea was given by the local chapter of the National Foundation on April 8 at the Hotel Bond.



## THE HISTORIAN'S NOTE BOOK

### CALEB HILLIER PARRY, THE DISTINGUISHED OLD BATH PHYSICIAN

GEORGE BLUMER, M.D., *San Marino, California*

ANYONE who had the privilege of serving under William Osler, either as a student or a house officer, was bound to hear of Caleb Hillier Parry. Dr. Osler usually spoke of him as "the distinguished old Bath physician," and loved, with a twinkle in his eye, to roll out his name in sonorous tones. "The Chief" was a great admirer of Dr. Parry and the two men had many characteristics in common: both were of Celtic origin, Osler Cornish, Parry Welsh; both were inveterate workers; both were keen observers of disease; both were kind and considerate to their patients; and both had a touch of a puckish sense of humor.

The Parry family had at one time owned large tracts of land in Wales but, being exceedingly prolific, these had in time become so split up by successive inheritances as to disappear as large holdings. Caleb Hillier Parry was the eldest of a family of three sons and seven daughters and had himself four sons and five daughters. His father, Joshua Parry, a Presbyterian minister, is said to have possessed a good deal of literary ability which, according to Dr. Rolleston, he dissipated in fugitive pieces: political, metaphysical, and satirical. His mother was the daughter of Caleb Hillier, after whom she named her eldest son. After Caleb Hillier's death his namesake inherited from him large estates in Gloucestershire, evidently not far from Bath which, while in Somersetshire, is only a few miles from the Gloucestershire border.

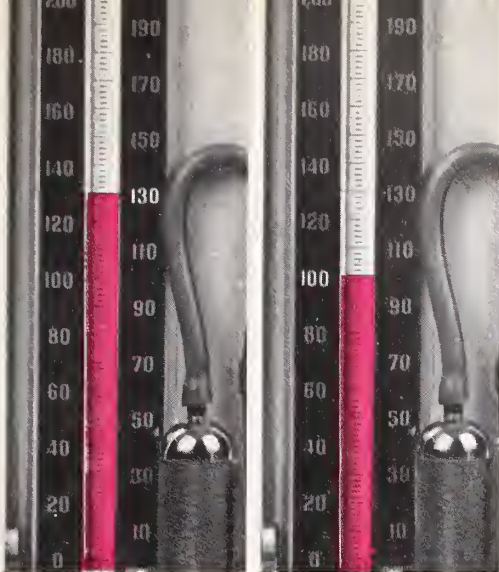
Caleb Hillier Parry's preliminary education was initiated in Cirencester where he was born in October 21, 1755.<sup>1</sup> There he was schooled under a Mr. Washburn and there too Edward Jenner was a schoolmate. Later he was sent to the Dissenter's School at Warrington in Lancashire where he came under the influence of John Aikin, a distinguished graduate in Divinity of Aberdeen University and the divinity tutor at Warrington Academy. His medical education began at the Edinburgh Medical School which he entered in 1773 and left temporarily in 1775. This was at a period when the celebrated

William Cullen was the Professor of the Theory of Physic, one of the first teachers in Great Britain to give clinical lectures in the vernacular instead of in Latin. In 1775 Parry moved to London where he was associated with Thomas Denman the elder, physician-accoucher to the Middlesex Hospital. Some time in 1777 he returned to Edinburgh and in 1778 obtained his M.D. degree, his inaugural thesis being on rabies. While there he was elected president of the Medical Society of Edinburgh, a post which Dr. Rolleston says was frequently "a nursery for later medical leaders."

In October 1778 Dr. Parry married a daughter of John Rigby of Lancaster. She is described as beautiful and amiable, and evidently had a good deal of charm, just the kind of wife he needed in Bath, the ancient *Aquae Calidae* or *Aquae Solis* of the time of the Roman occupation of Britain. The city, situated on the river Avon in Somersetshire, was a health resort with thermal springs and, at the time Dr. Parry and his bride settled there in 1779, after a tour of important medical centers on the Continent of Europe, Bath was still frequented by many prominent people. No doubt a woman with Mrs. Parry's amiability and charm was a great social asset to her husband who, in the course of years, met many celebrities and doubtless was the medical adviser to some of them. Being of an enquiring mind Dr. Parry picked up from these visitors a great deal of information, especially regarding military and naval life, as is recorded by Dr. Rolleston.

Almost every young man beginning his career as a physician in a strange city takes time to gain a foothold on the first rung of the ladder of success and Caleb Hillier Parry was no exception. However, it is evident that he got a quicker than average start and his progress was recorded as rapid. After ten years his professional income exceeded fifteen hundred pounds per annum, a comfortable sum in those days, and he eventually earned as much as six hundred pounds a month.

Dr. Parry was an inveterate notetaker and a

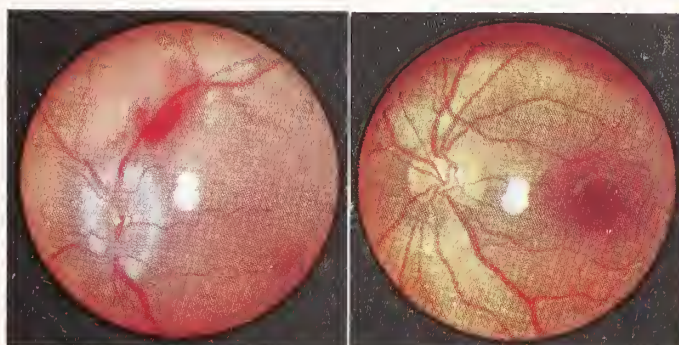


#### APRESOLINE REDUCES DIASTOLIC PRESSURE

Diastolic pressure reduced to level considered normal in one-quarter and to 110 mm. Hg or less in one-third of 97 patients receiving oral Apresoline for periods ranging from 3 months to 1 year or longer;<sup>1</sup> hypertension in which neurogenic or psychogenic mechanisms predominated most improved; patients with severe as well as moderate hypertension benefited.

#### APRESOLINE LESSENS RETINAL ARTERIOLAR CONSTRICTION, RETINAL HEMORRHAGES\*

Lessening of retinal arteriolar constriction; disappearance of retinal hemorrhages; remittance of hypertensive headaches, giddiness, paresthesias, transient pareses, and encephalopathies; some evidence of improved mental alacrity.

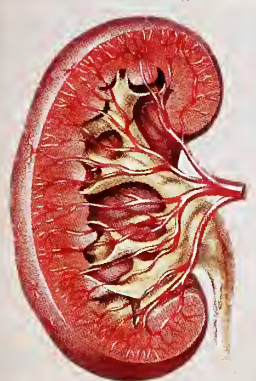


#### APRESOLINE INCREASES RENAL BLOOD FLOW

Renal improvement less marked than cerebral improvement, but renal blood flow and filtration rate increased and hematuria and proteinuria remitted in some cases; hypertensive heart disease little improved and, in some cases, worsened.

*Side Effects:* Side effects "minor, transient, or remediable" in most cases.

Headache, gastrointestinal upset, periorbital and ankle edema, and a "grippe-like syndrome"—involving malaise and muscle and joint pain (see note)—observed.



# Apresoline®

**NOTE:** Appearance of arthritis-like symptoms during Apresoline therapy is an indication for cessation of treatment. Experience has shown that the phenomenon remits spontaneously on withdrawal of the drug. These symptoms are not likely to occur in patients who receive a daily dose of 400 mg. or less.

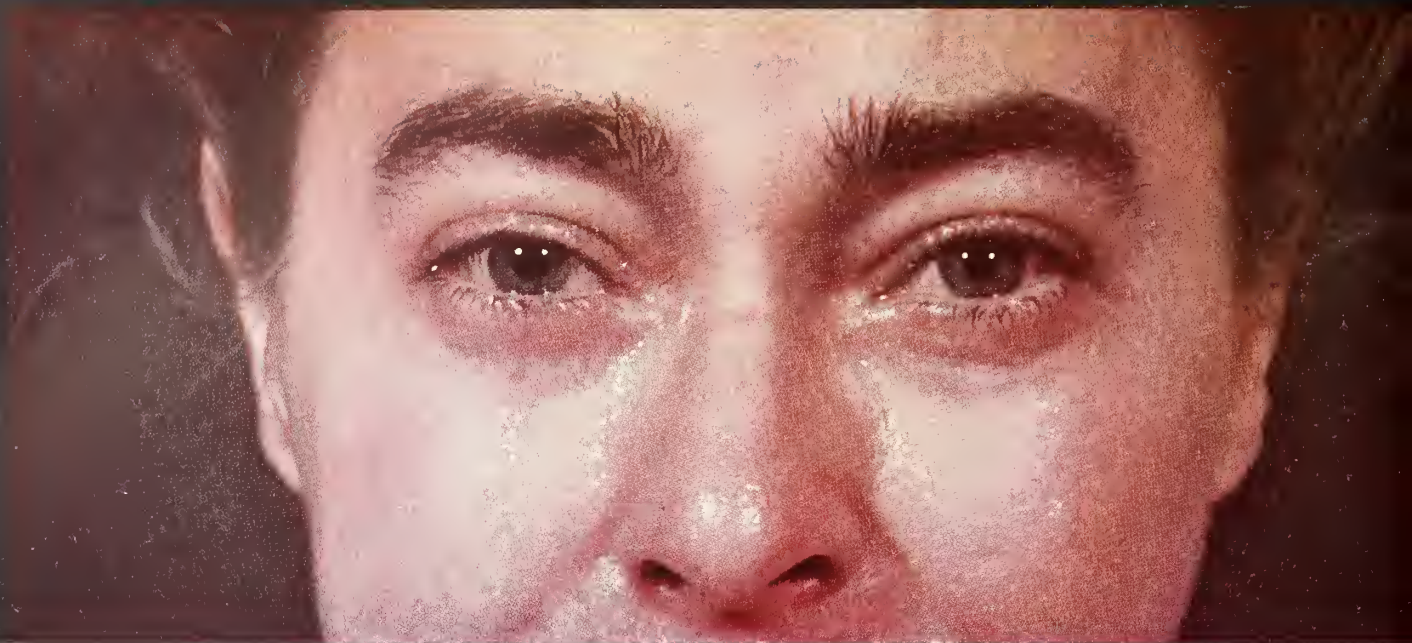
**FOR COMPLETE INFORMATION** on Apresoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Apresoline hydrochloride (hydralazine hydrochloride CIBA) 10-mg. tablets (yellow, double-scored), 25-mg. tablets (blue, coated), and 50-mg. tablets (pink, coated) in bottles of 100, 500, and 1000; 100-mg. tablets (orange, coated) in bottles of 100 and 1000.

1. TAYLOR, R. D., OUSTAN, H. P., CORCORAN, A. C., AND PAGE, I. H.: ARCH. INT. MED. 90:734 (DEC.) 1952.

\*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

# C I B A





#### **ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES**

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin<sup>1</sup> found Pyribenzamine beneficial in 82% of 107 patients; Feinberg<sup>2</sup> noted relief in 82% of 254 cases; Gay and associates<sup>3</sup> in 76% of 51 cases; Arbesman and colleagues<sup>4</sup> in 84% of 106 cases. In a later study Arbesman<sup>5</sup> rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."<sup>6</sup> Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

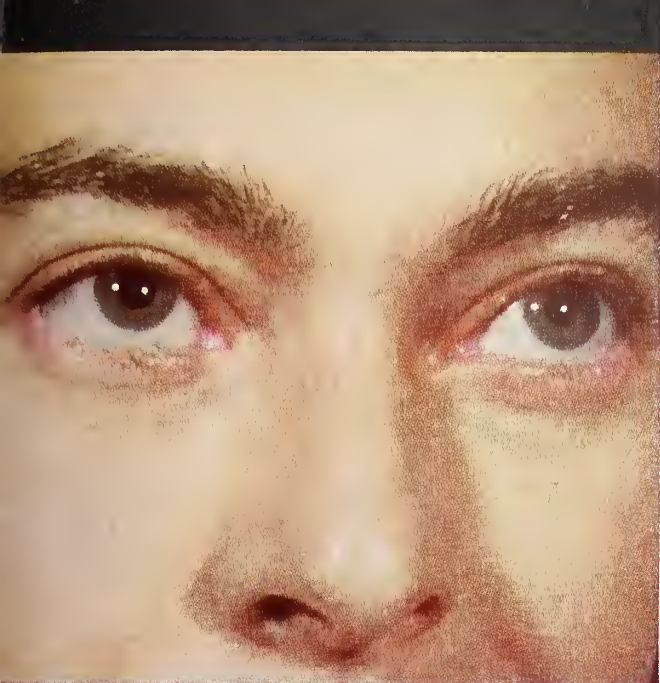
#### **CONTROLS PENICILLIN REACTIONS**

Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten<sup>7</sup> found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

#### **RELIEVES ALLERGIC DERMATOSES**

Foster<sup>8</sup> reported good results with oral Pyribenzamine in patients with various allergic dermatoses. In another study<sup>9</sup> of 241 such patients, Pyribenzamine was found effective.





*Pyribenzamine 25-mg.  
tablets now available—  
for children and for adults  
who can be maintained  
on low dosage or  
who experience side effects  
from the usual dosage  
of antihistamines*

**PUBLISHED CLINICAL STUDIES  
SHOW THOUSANDS OF  
ALLERGIC PATIENTS  
RELIEVED BY**

*Supplied:* Pyribenzamine hydrochloride 25-mg. and 50-mg. tablets; Pyribenzamine Elixir, 30 mg. Pyribenzamine citrate (equivalent to 20 mg. tripeleannamine hydrochloride) per 4-ml. teaspoonful; Pyribenzamine hydrochloride solution (for parenteral use), 25 mg. per ml., in 1-ml. ampuls.

# Pyribenzamine®

PYRIBENZAMINE HYDROCHLORIDE (TRIPLENNAMINE HYDROCHLORIDE CIBA)  
PYRIBENZAMINE CITRATE (TRIPLENNAMINE CITRATE CIBA)

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3. Gay, L. N., Landau, S. W., Carliner, P. E., Davidson, N. S., Furstenberg, F. E., Herman, N. B., Nelson, W. H., Parsons, J. W., and Winkenwerder, W. W.: Bull. Johns Hopkins Hosp. 83:356 (Oct.) 1948.
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9. Morrow, G.: California Med. 69:22 (July) 1948.

For complete information on Pyribenzamine ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J.





**INCREASES PERIPHERAL BLOOD FLOW:**

Priscoline reported to be a valuable aid to conventional therapy in peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, other trophic manifestations; Priscoline most effective when vasospasm is prominent but may prove limb-saving even when vasospasm is minimal because it decreases vascular tone, promotes establishment of collateral circulation.

**MULTIPLE ACTION:**

Priscoline exerts direct vasodilating effect on vessel wall, blocks sympathetic nerves (probably at their terminations in vascular muscle), blocks vasoconstrictive action of circulating epinephrine-like substances.

*Side Effects:* Certain side effects of Priscoline—"crawling" cutaneous sensation, chilliness with resultant gooseflesh or feeling of warmth—indicate attainment of effective dosage level; occasionally tachycardia, tingling, nausea and epigastric distress, slight hypotensive effect or slight rise in blood pressure may be experienced.

**AGE 75.** Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



**AGE 68.** Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.

# Priscoline®

**FOR COMPLETE INFORMATION** on Priscoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Priscoline hydrochloride (tolazoline hydrochloride CIBA) is available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.

voluntinous writer and was a member of a medical society of five members which met thrice annually, usually at Rodborough in Gloucestershire. They were intimate friends, some like Jenner former schoolmates, others men whose professional attainments he admired. Beside Drs. Jenner and Parry there were Dr. Hickes of Bristol, Dr. Ludlow of Corsham and Mr. Patherus, doubtless a surgeon,<sup>2</sup> of London. While it is doubtful that they always saw eye to eye on professional matters, such a group, capable of disagreement without acrimony, no doubt stimulated and educated each other.

According to his life history in the Dictionary of National Biography, Dr. Parry's most important work was his "Experimental Inquiry into the Nature, Cause, and Varieties of the Arterial Pulse; and into Certain Other Properties of the Larger Arteries, in Animals with Warm Blood." I suspect the reason for this appraisal was the fact that it was based on experimental work and that even in those days experimentation was more highly regarded than clinical research. The book is clearly written and shows that arteries do not, as one might suppose, show visible pulsation or movement when exposed, although the pulse can easily be felt by palpation. These vessels may shift with respiration except during the brief period of apnea. The second part of the book is concerned with descriptions of the anatomy, histology, and chemistry of the different coats of vessel walls. In the course of the work Dr. Parry comments on the use of the term *lusus naturae* by certain writers who are unable to explain their observations. He says: "This term, *lusus naturae*, is an extremely convenient mode of cutting a knot, which we have not the ingenuity or the patience to untie."

Dr. Parry is best known for his clinical observations on exophthalmic goiter, angina pectoris, and rabies and tetanus.

He first noted the clinical picture of exophthalmic goiter in 1786 but did not fully recognize it until 1813 at which time physiologists had not discovered the function of the thyroid gland. However, as Fielding Garrison points out, his notes on the disease taken in 1786 are so complete and original that they more justly entitle him to the honor of its discovery than the accounts later published by Joseph Flavani (1800), Robert James Graves (1835) or Carl Adolf Basedow (1840).

Dr. Parry's account of angina pectoris, which he called Syncope Angens because Anginosa is not strictly Latin, was published in 1799 after being

read to his small medical group. William Heberden the Elder had recorded 20 cases, but no autopsies, in 1768. Edward Jenner, one of the group, had already concluded that angina was due to coronary artery disease but had deferred publication of this view because he feared it would have an untoward effect on his old friend John Hunter, a victim of the disease. As a matter of fact, Hunter had done an autopsy on a patient of John Fothergill who died of angina pectoris, and had himself found coronary disease and this only three years after he had developed it. Caleb Parry had also autopsied some of his patients and knew of the association with disease of the coronary arteries.

Caleb Parry's account of rabies and tetanus was really a study of a disease in which he had long been interested for, as already recorded, his inaugural dissertation was on rabies. In his book he not only graphically described cases of hydrophobia and lock-jaw but emphasized certain facts, of which perhaps the most important was that of persons bitten by rabid animals only a small percentage developed the disease. He clearly differentiated rabies from tetanus, the great difference in the period of incubation of the two diseases being emphasized as one very important point. He also described pseudo-rabies in neurotics who had been bitten and feared the disease, and he pointed out also that the supposedly curative value of many popular remedies was entirely fallacious because most people who had been bitten by rabid animals did not develop the disease at all. He plainly stated that the mortality of real rabies was 100 per cent.

In the course of his life Dr. Parry made other observations of interest: In 1814 he described the first recorded cases of facial hemiatrophy; in 1825 he described idiopathic dilatation of the colon; he claimed that globus hystericus was due to an actual spasm of the upper air passages and could be alleviated by pushing the larynx downward. His insight into what is now known as psychosomatic medicine is shown by a remark: "It is much more important to know what sort of a patient has a disease, than what sort of a disease a patient has." He was indeed a master clinician.

In spite of his medical activities Caleb Parry found time to cultivate some hobbies. He made a large collection of the fossils of Gloucestershire, but his main hobby was agriculture, including animal husbandry. He bought a farm near Bath where he bred sheep with the idea of improving the quality of their



wool, and he practised scientific farming. He was a member of several agricultural societies. All in all an extraordinary individual. He died March 9, 1822, six years after a stroke which left him with right sided hemiplegia and partial aphasia but did not impair his mental activities nor his sense of humor.<sup>3</sup>

#### REFERENCES

1. English towns with names ending in Cester, Chester or Caster were Roman camps during the Roman occupation of Britain.
2. The British call surgeons Mister not Doctor.
3. Dr. Humphrey Rolleston's article in *Annals of Medical History*, 1925, Vol. 7, No. 3, is the most elaborate article on Caleb Hillier Parry but is somewhat cursive. Volume 15 of the *Dictionary of National Biography* also contains a long account of his life, and Munk's history of the College of Physicians, 2d Edition, Vol. 2, page 385, 1878 contains a valuable biography.

### Filter Holder Most Effective

An American Medical Association study indicated recently that a cigarette holder using a second cigarette inside the cylinder as a filter is more effective in screening out nicotine and tars than four other filter type holders tested.

Two of the holders tested used a metal trap like those found in many pipes, the third used a cylindrical paper filter and contained a number of small paper baffles, while the fourth was filled with granules of silica, which filtered the smoke.

Dr. Walter Wolman, PH.D., director of the AMA Chemical Laboratory, said tests of the holders on a smoking machine showed:

One filter holder using a metal trap screened out 5 per cent of the nicotine and 8 per cent of the tars; the second metal trap holder screened out 4 per cent and 11 per cent; the paper filter, 7 per cent and 9 per cent; the silica granules filter 14 per cent and 21 per cent and the cigarette filter, 41 per cent of both nicotine and tars.

The report of the study, published in the *AMA Journal*, said all types of holders except the cigarette filter holder, lost some efficiency after five cigarettes were smoked.

### Responsibility of the Surgeon

In a report from the Committee on Third Party Payments to the Council of the State Medical Society

made several months ago certain recommendations were made which would permit members of the resident house staff of any hospital to bill patients with prepayment surgical insurance upon whom they performed surgical operations, or would permit a hospital to bill such patients and turn over the funds thus received to the staff for use in a program of medical education in that particular hospital. Both these procedures were objected to by some members of the Council. Attention was called to the fact that certain insurance companies will now pay surgeons who signify in writing that they were personally responsible for such surgery performed by members of the resident house staff, even though they did not themselves actually perform the operation. It was also pointed out that one of the principal voluntary prepayment insurance carriers, Connecticut Medical Service, does not have a claim form which permits this procedure. This latter carrier was therefore approached and in order to settle the question legal advice was sought by the director of CMS. The correspondence is self explanatory and is reproduced here.

February 5, 1954

Mr. William B. Gumbart  
New Haven, Connecticut

Dear Mr. Gumbart:

We would appreciate your opinion regarding the following:

The present CMS claim form, a copy of which is attached, requires the attending physician to certify that he has "performed" the services for which payment is requested.

We have been asked if it is possible for CMS to make payment on claims whereon the physician signing the claim form indicates that he was "responsible for" the services for which payment is requested.

The request seems to arise from the situation which exists in some hospitals where doctors of medicine in training programs render certain professional services as part of their training, the responsibility for which is assumed by a staff physician. In some instances, the so-called "responsible" physician is in immediate attendance at the time the services are rendered by the physician in training; in other instances it is my understanding that the "responsible" physician is not present, and in some cases may not even be in the hospital.

I will be pleased to discuss the matter with you at your convenience if you would like to do so.

Very truly yours,  
/s/ W. H. Horton, M.D.,  
Executive Director

February 11, 1954

Dr. W. H. Horton,  
New Haven 9, Connecticut.

Dear Dr. Horton:

This is in reply to your letter of February 5, 1954, concerning the question whether CMS should make payment of claims where the physician making the claim did not perform the operation, but merely states that he was responsible for it. This will confirm the conclusion reached at our discussion of the matter.

In my opinion it would be inimical to the best interests of Connecticut Medical Service to pay such claims. It also seems to me that it would be contrary to the public interest, and since we are a nonprofit tax free institution, we should be especially concerned with the public interest. The proposal would open the door to bad practices, some of which have been recently exposed.

I enclose two extra copies of this letter for your convenience.

Very truly yours,  
/s/ W. B. Gumbart

### New Trustees to Yale Medical Library Associates

Gilbert W. Heublein and John C. Leonard of Hartford and Edward Ottenheimer of Willimantic were recently elected new trustees of the Associates of the Yale Medical Library to replace those whose terms had expired.

Herbert Thoms of New Haven was re-elected chairman for another term and the secretary reported that Samuel C. Harvey's widow had given \$1,500 to establish a book fund in memory of Dr. Harvey.

### Court Halts "Electronic" and "Orgone Energy" Cures

Thirteen electrical devices which have been widely distributed for the diagnosis and treatment of serious diseases were barred from shipment in interstate commerce by an injunction decree entered

March 16 in the Federal district court at San Francisco.

The Electronic Medical Foundation of San Francisco consented to the entry of the decree, which is also binding upon the officers of the Foundation and all persons in active concert or participation with them.

The Food and Drug Administration, U. S. Department of Health, Education, and Welfare, which initiated the injunction suit, estimates that there are about 5,000 of the devices now in the offices of various fringe practitioners throughout the country. The names of the machines are as follows:

Oscilloclast	Depolaray
Oscillotron	Depolatron
Regular Push Button Short-wave Oscilloclast	Depolaray Chair
Sweep Oscillotron	Depolatron Chair
Sinusoidal Four-in-One	Depolaray Junior
Shortwave Oscillotron	Electropad
Galvanic Five-in-One	New Depolaray Junior
Shortwave Oscillotron	

In addition to these machines the decree bans interstate shipment of "Blood Specimen Carriers" for use in a diagnostic machine, the Radioscope, which is maintained at the Foundation's offices in San Francisco. It also bans the shipment of any similar electrical devices for producing or measuring low-power radio waves or magnetic energy or any accessories or parts of such devices.

The Government charged that all the devices are misbranded, since they are not capable of diagnosing or curing any disease, much less the hundreds of serious diseases which it was claimed they will diagnose and treat effectively. According to FDA investigators, the Foundation claimed it could diagnose any disease from dried blood samples sent in through the mails. Some of the results of their sleuthing: diagnosis of arthritic involvement in right leg (but subject's right leg had been amputated years before); blood from cadaver brought finding of colitis; spot of coal tar dye, purportedly taken from a woman, elicited diagnosis of toxemia. Therapeutic machines marketed by the firm were found worthless by FDA, though literature recommended them for enlarged prostate, mastoiditis and cancer.

"Orgone energy" devices misbranded with curative claims were barred from interstate commerce by a permanent injunction order issued March 19 in the Federal district court at Portland, Maine, by

(Concluded on page 460)



## Special Article

### HOW TO DIE LIKE A MILLIONAIRE

CHARLES T. KINGSTON, JR., *Hartford*

The Author. *Proprietor, Charles Kingston & Associates, Personal Estate Planners and Personal Insurance Counselors*

#### FOREWORD

The information in this article was developed with the complete cooperation of the staff of the Hartford County Medical Association. They made available to us the obituary files of the Association for the period January 1, 1940 to May 1, 1953. In addition we reviewed the records of the Probate Court for Hartford County.

Statistics developed from this research can not be considered conclusive. We studied only the estates of members of the Association who died during the period under scrutiny. In all we reviewed 144 probates files—hardly a sufficient number upon which to develop firm statistical data. Yet the things we did learn are of infinite value to us since we do specialize in estate planning for professional persons.

We refer to this experience as an "Economy Autopsy." By learning what problems were involved in settling the estates of these 144 doctors, our recommendations to our clients are far more realistic and infinitely more constructive than would otherwise be possible.

The doctor-millionaire who made his money from his practice is as rare as a dinosaur, our recently made survey of probate court records in Hartford County (Connecticut) has revealed. From 1940 to 1953, only 1.6 out of 100 Hartford County Medical Association doctors left estates in excess of \$1,000,000—and only one of them accomplished this feat through his professional earning power. Incidentally, estate taxes and other settlement expenses consumed \$575,915 of what he left.

#### BEST YEARS WERE 20'S AND 30'S

Those who did accumulate sizable estates had their peak productivity in the 1920's and 1930's—when personal income taxes and business expenses were smaller. A hypothetical example: the doctor

#### SUMMARY

A recent analysis of the Probate Court records for Hartford County reveals rather conclusively that medical men need professional help in their financial planning from the very moment they start to practice. Depreciation in value and various taxes consumed much of the physicians' estates.

There are two vulnerable age periods for physicians, 41 to 50 and 61 to 70. In many cases no will had been made, thus creating a problem. There are certain items which a will should cover, such as naming the executor, payment of mortgages, planning of trusts, and making of bequests.

The Annuity Principle is outlined and the best method of planning an estate is suggested. Competent assistance is advised in estate planning.

whose practice extends from January 1940 to January 1965 and whose net income, after deducting business expenses, real estate taxes, mortgage interest, contributions, etc., is \$15,000 each year, can expect to pay income taxes totalling \$91,100\* over this span of time (based on the present income tax structure). On the other hand, a doctor practicing from 1915 to 1940 whose net income was \$15,000 each year, would have paid approximately \$20,350\* in taxes during that 25 year period. Ergo, he could leave a sizable estate by saving no more than today's practitioner pays in income taxes.

#### 13 PER CENT IN DEBT AT DEATH

Despite the opportunities to accumulate wealth during the early decades of this century, 13 per cent of Hartford County doctors were in debt at death, 31 per cent left estates less than \$10,000 and 83 per cent died leaving less than \$100,000.

\*A married man without children

### ESTATES SUBJECT TO PROBATE

GROSS VALUE	PERCENTAGE
Less than \$10,000.....	31
\$ 10,001 to \$25,000.....	21
\$ 25,001 to \$50,000.....	15
\$ 50,001 to \$100,000.....	16
\$100,001 to \$300,000.....	10
\$300,001 to \$500,000.....	3.8
\$500,001 to \$1,000,000.....	1.6
Over \$1,000,000 .....	1.6
Total .....	100

Sixty-seven per cent of the estates also paid a Connecticut Succession Tax which averaged 3.8 per cent. Thirty-eight per cent were also exposed to a Federal Estate Tax liability which averaged 16.8 per cent.

All of the estates were subject to a depreciation of at least 12.3 per cent as they went through probate:

AVERAGE ESTATE SETTLEMENT COSTS	AVERAGE PERCENTAGE
Bills payable .....	2.6
Funeral expenses.....	1.2
Miscellaneous administration expenses.....	1.3
Other expenses (lawyers, appraisers, etc.).....	1.3
Executor's or administrator's fee.....	2.4
Widow's allowance during estate settlement.....	3.5
Total .....	12.3

In summary then:

One-third of the estates depreciated.....	12.3
Two-thirds depreciated at least.....	16.1
The larger estates depreciated.....	32.9

### MORTALITY BY AGE GROUPS

PERIOD	*STANDARD MORTALITY TABLE	HARTFORD COUNTY M.D.'S
Between age 41 and 50.....	7.7%	15.3%
Between age 51 and 60.....	14.1%	11.9%
Between age 61 and 70.....	23.2%	35.6%
Between age 71 and 80.....	27.0%	25.4%
Between age 81 and 90.....	14.1%	5.1%

### TWO VULNERABLE AGE PERIODS

Age at death of Hartford County physicians compared to the Insurance Commissioners' Standard Table of Mortality shows that there are two vulnerable age periods for medical men—41 to 50 and 61 to 70. Incidentally, five female doctors died at an average age of 69½ years. Hartford County seems

to be a healthy location for female practitioners. In only 54 per cent of the cases studied was the cause of death known, but where known, 51.5 per cent died of coronary disease, and 12 per cent from cerebral hemorrhage. Furthermore, Hartford County doctors do leave dependents. Sixty-two per cent were survived by a wife and from one to seven children, and fourteen per cent by a wife and no children. Only 12 per cent lived longer than their wives.

### ABSENCE OF A WILL CREATES PROBLEMS

In the matter of willmaking, 34 per cent of the doctors died without a will. Sixty-seven per cent of these physicians left wives and children. Under Connecticut law, the estate is divided one-third to the spouse and two-thirds equally among the children. This may or may not have been the distribution the doctor desired. Many problems may arise when the ownership of property vests in minor children.

Where no will existed, in 95 per cent of the cases, the court appointed the wife as administratrix of the estate. In only four cases out of 100 did banks get the assignment.

Where the decedent had given some thought to his will and to the distribution of his estate, trust companies were named executor in exactly one out of every three cases. Nearly as many (30 per cent) of those who died testate—with an acceptable will—created testamentary trusts for their beneficiaries.

### CHECK THESE ITEMS WHEN MAKING A WILL

From our exposure to how Hartford County Medical Association doctors handled their estates we have developed some firm convictions. One of the most important is this, make a will, if you don't have one, and periodically review existing instruments with your attorney and your estate planner. Discuss the following items:

### WHO IS TO BE THE EXECUTOR?

There are about 46 mechanical procedures involved in settling an estate. If you name your wife, she will have a tedious and unpleasant task at a time when she is least fit to handle it. Consider a corporate fiduciary as executor, or as coexecutor with your wife, if you feel that she should have this responsibility. You will probably not lessen settlement costs by naming your wife as executrix. Our statistics reveal that, while you may save an executor's fee, she in turn will incur legal fees and other expenses which tend to offset any savings effected. In Hart-

\*Insurance Commissioners' Standard Table of Mortality



ford County, at least, estates are settled more rapidly by banks than by any variety of individual executor.

#### GUARDIAN OF MINOR CHILDREN

Be sure to name the person you would prefer to have manage property for minor children. You should also include a statement to the effect that children born or adopted after the execution of the will shall not invalidate the instrument and that such children are to share equally with others.

#### MORTGAGES

Consider whether or not the executor is to pay off the residential mortgage along with other debts. If he is, be sure that he has enough cash assets to do so. Otherwise, direct the executor to pay debts, "except those secured by mortgage."

#### ESTATE TAXES

Very often wills direct that federal estate and state succession taxes be treated as an expense of administration and not prorated among nor charged to any beneficiaries. This may facilitate settlement, but it is important that your estate planner estimate what these tax liabilities and other settlement expenses will be. Then you and he must determine what assets are to be used to pay these inescapable expenses. Equally important, then, is the ready availability of funds earmarked for this purpose.

#### TESTAMENTARY TRUSTS

The idea of putting property into trust for the family appeals to many persons. It also has decided tax advantages in some situations. Estate planners and trust officers usually recommend trusts of different varieties to accomplish specific purposes. Before creating such a trust, determine whether your estate will be more valuable to your heirs in such a form. For instance, one 49 year old doctor died leaving an estate of \$19,864.69 to be in trust until the younger of two boys attained age 30. Estate settlement costs totaled \$5,254.50. Property owned jointly with his wife and given outright to her was valued at \$7,388.63. Only \$7,221.56 was left to be turned over to the trustees, of which \$6,504.38 constituted "Accounts Receivable." Fortunately the receivables were all collected but such a trust serves a doubtful purpose, unless there are very unusual circumstances.

#### EX-WIVES

If you are paying alimony or have other fixed obligations to a divorced wife, see that such matters

are a part of your estate plan. The claims of an ex-wife for maintenance and repairs to her residence delayed the settlement of one estate for over four years.

#### BEQUESTS

Gifts to hospitals, clinics, charitable institutions and to individual persons are not uncommon. They are usually fixed amounts. It is our suggestion that you first determine the minimum the estate will provide. Then calculate how much of the estate your family will need. What is left can be divided among your pet charities and favored individuals. However, it is wise to qualify bequests in some way. For instance, (1) as a percentage of the estate subject to probate; or (2) by reducing gifts or eliminating them, if the estate is less than a specified amount. If gifts are fixed at the time of the will making, and if later your estate depreciates drastically in value, the payment of the bequests may penalize the family severely.

#### COMPETENT MANAGEMENT IS VITAL

Whether your estate is small or large, you should be interested in preserving anything you have accumulated. As a matter of fact, the smaller the estate, the more vital that it be competently managed. Millions of dollars are unnecessarily dissipated in estate taxes and associated settlement expenses simply because doctors are too busy with their day-to-day affairs to arrange their estate in the best and most efficient way.

Here is the situation of the typical member of the Hartford County Medical Association (and medical societies everywhere). Unless he knocks himself out between 40 and 50, he has a better than even chance to live a full life span. He will earn a good living for about 25 years. Then younger men with new techniques will come up and he will slow down. His income will decrease and eventually disappear unless he has accumulated some kind of income-producing property to pick up the slack when his professional productivity declines.

Furthermore, our study indicates that if a fair sized estate is developed, it will depreciate about 33 per cent as it goes through probate—an estate is practically evaporated in three generations. The day when one could accumulate property, live on the income, and then pass on the property intact to succeeding generations is gone.

#### THE ANNUITY PRINCIPLE

The 1954 practitioner, if he is interested in protecting himself, can develop a minimum percentage of economic independence through interest on capital and the gradual liquidation of that capital, better known as the "Annuity Principle." He should combine that general economic concept with life insurance by which he immediately creates an estate that serves his minimum needs and he then pays for it on the installment plan during his productive years. If he survives the rigorous forties and less hazardous fifties, he begins to supplement his decreasing professional income through the liquidation of his capital accumulation.

#### "FINANCIAL MEDICINE"

Estate planning is, in effect, the practice of financial medicine. Select your adviser with care and then give him the data he needs. He cannot recommend constructive action if he has only pieces of information or knows only part of your financial affairs. In fact, proper estate planning cannot be limited to your situation exclusively or even to a single generation. A basic function of estate planning is to coordinate the economic plans of the family in order to conserve property and, if possible, add to the family fortune.

#### DEVISE A MASTER PLAN

The estate planner must form one estate plan which is designed:

1. To obtain the maximum utility of all assets during your lifetime. This includes your earning capacity—your most valuable asset. (A man whose gross income is \$30,000 per year is a very valuable piece of human property. It would take \$500,000 of property well invested at 6 per cent to produce an equivalent income.)
2. To minimize the depreciations which take place while the estate is in probate.
3. To make certain that the surviving heirs get the most out of the assets.

#### OUR FINAL WORD OF ADVICE

The earlier in your professional career you seek and obtain the service of a competent estate planner, the less complicated and expensive your economic life and that of your heirs will be. You owe yourself reasonable assurance of financial independence as your reward for a lifetime of hard work. Intelligent financial planning can give you such assurance.

Though Federal and State taxing systems reduce estates, they do leave openings which can accrue to the wise planner—but no matter how you try, you can't die like a millionaire from fees alone.

### The Art Musicale

About 150 members of the Connecticut State Medical Society and their wives, members of the Auxiliary, enjoyed a very pleasant evening at the Avery Memorial in Hartford on March 28. There was a special exhibit of paintings offering much to delight the eye, a social hour, a sumptuous buffet, and a delightful musical program.

Participating artists included Mrs. Marynka Crosby of Hartford at the piano; Dr. Robert Berneike of New Britain, clarinetist, accompanied by his wife, Elaine; Mrs. Edythe Spektor of Hartford, soprano, accompanied by Mrs. Beatrice Sewall; Dr. J. B. Sigal of Hartford, violinist, accompanied by Mrs. Crosby; and Mrs. Sewall, piano soloist. The final number on the program was presented by a quartet of Hartford physicians in costume, Frank McCarthy, Archibald S. Deming, James Johnson, and John Wells.

To Dr. Roberts of New Haven ably assisted by Mrs. David Waskowitz of New Britain and her committee goes the credit for this second successful Art-Musicale.

### CMS Celebrates

Connecticut Medical Service celebrated the fifth anniversary of its founding with a dinner at the New Haven Lawn Club on April 1 at which Charles P. Chambers of South Coventry was presented with an \$100 U. S. Defense Bond by President Robert S. Judd. Mr. Chambers became the 750,000th member of CMS. Dr. Thomas J. Danaher, vice-president of CMS and chairman of its Professional Policy Committee, presented commemorative certificates on behalf of the CMS Board of Directors to Mr. Chambers, a jet engine tester at Pratt & Whitney, and to Morgan Mooney, assistant personnel director of United Aircraft Corporation, of which Pratt & Whitney is a division. The anniversary was also celebrated by the presentation of achievement citations to the plan by Frank E. Smith of Chicago, director of Blue Shield Medical Care Plans, Inc. The presentation was received by Dr. William H. Horton, executive director of CMS.



## Legislative Article

### SOCIAL SECURITY

#### Present Attempt to Include the Self-Employed Professionals

DAVID M. RICHMAN

*The Author. Chairman of The Social Security Committee of the New Haven County Bar Association*

FOR nineteen years self-employed professionals have been excluded from the provisions of the Social Security Laws. (Sec. 211) (c) (5). The administration bill introduced in Congress, known as the Reed bill, HR7199, provides for the inclusion of physicians, dentists, lawyers and other self-employed professionals under the Social Security Act.

The Reed bill includes the following amendments to the present Social Security Act:

(1) The major groups for which coverage is recommended on a compulsory basis are farm operators, self-employed professional groups now excluded, and hired farm workers and household workers who receive at least \$50 a quarter cash wages from an employer. Coverage is recommended on a voluntary basis for clergymen employed by non profit organizations and for employees covered by state and local government retirement systems, except policemen and firemen because their occupations are considered too hazardous.

(2) The maximum annual earnings on which contributions are based and benefits computed would be raised from \$3,600 to \$4,200 per year.

(3) Up to four years of lowest or no earnings would be omitted in computing the average monthly wage, such provisions to be generally applicable for persons coming on the rolls in the future.

(4) All retired workers would receive a benefit increase of at least \$5 and dependents would generally receive proportionate increases.

The present Social Security annual payment schedule, designed to keep the system self supporting, is as follows:

	PAID BY EMPLOYEE PER CENT	PAID BY EMPLOYER PER CENT	SELF EMPLOYED PER CENT	\$4,200 BASIS COST TO SELF EMPLOYED
1954-1959	2	2	3	\$126.00
1960-1964	2½	2½	3¾	157.50
1965-1969	3	3	4½	199.00
1970 and after	3½	3½	5¼	220.50

These tax contributions go into the Old-Age and Survivors Insurance Trust Fund, which under the law can be used only to pay Old-Age and Survivors benefits and the cost of administering the program. The assets of the fund, which are not needed for current disbursements, are invested in interest-bearing U. S. Government bonds. Interest on these investments amounted to 400 million dollars in 1953. The interest also goes into the Trust Fund. The Trust Fund now amounts to 18.7 billion dollars.

Self-employed professionals like physicians, dentists and lawyers differ from wage earners and should not be included in the provisions of the Social Security Act, because employed persons generally work until they reach a fixed retirement age of, say, 65 and then cease work abruptly and completely. Physicians, dentists, lawyers and other self-employed professionals are not forced into abrupt and complete retirement at 65. They usually continue in practice and are generally at the height of their earning power at that age.

The present Social Security Act was designed solely to meet the needs of employed persons and neither its original proponents nor its draftsmen purported to consider the problems of self-employed

professionals. This is proved by the fact that the original Act and all amendments since, have specifically excluded physicians, dentists, lawyers and other professionals who have been self employed.

Most physicians, dentists and lawyers, if they were covered by the present Act would make substantial payments all of their professional lives, only to find at age 65 that they are disqualified to receive benefits because they earn more than \$1,000 per year.

It is to be noted that the self-employed professional would pay from 3 per cent to 5¼ per cent of the maximum (\$4,200)—and this may be increased over the years up to \$6,000—for a number of years which would amount to a substantial sum.

Self-employed professionals cannot afford to pay the high rates on the maximum for many years and not be able to participate in the benefits until age 75. From age 65 to 75 they draw benefits if they earn no more than \$1,000 annually. If they die, widows cannot draw benefits if under 65. They can only receive benefits for children until they reach 18 years.

#### WE PROPOSE PASSAGE OF THE JENKINS-KEOGH BILL

The Jenkins-Keogh bill allows a self-employed person to participate in a qualified plan to deduct from gross income each year a limited amount of "earned income" contributed by him to a "restricted retirement fund" or paid in as premiums to purchase a "restricted retirement annuity contract." He can deduct annually up to \$7,500 or 10 per cent of earned income, whichever is less, but not more than a total of \$150,000 during his lifetime. There is a five year carryover of unused deductions.

An individual who has reached age 55 before January 1, 1953 is allowed to deduct an additional amount, so that he may build up an adequate interest in the fund or more than a token annuity. In his case, the normal deduction limit is increased by the lesser of \$750 or 1 per cent of his earned income, multiplied by the number of years of his age in excess of 55 (as of January 1, 1953).

If a taxpayer contributes to a restricted retirement fund (there must be a corporate trustee), he cannot withdraw his interest in the fund before reaching age 65, unless he becomes totally and permanently disabled. Though he cannot assign his interest, he has the right to designate one or more beneficiaries to receive any part to which he may be entitled at death. He also has the right to designate

his spouse or other dependent as a survivor, or joint and survivor annuitant under an annuity contract that he may receive from the trust.

On attaining age 65 or on sooner disability, he will get back his contributions to the fund plus their accumulated earnings in one of three ways elected by him:

(1) A lump sum.

(2) Annual, quarterly, or monthly installments over a period of years, or

(3) One or more single premium life annuity contracts.

Likewise, if the taxpayer buys a restricted retirement annuity contract from an insurance company, he cannot begin to receive annuity income before age 65 or permanent and total disability. A similar condition applies to refunds, cash surrender, or other money benefits, and the right to assign and designate beneficiaries is the same as that of a participant in a restricted retirement fund.

Like a qualified pension or profit-sharing fund under Sec. 165 (a) of the Internal Revenue Code, a restricted retirement fund is tax exempt. Also, the self-employed individual (or employee not eligible to participate in a qualified plan) pays no tax until he actually is paid benefits. Then, however, he pays income taxes on the full amounts distributed to him periodically from the fund or under his annuity contract when he retires or becomes disabled. If he or his beneficiary gets his portion of the trust fund in a lump sum after it has accumulated for more than five years, it is taxed as long-term capital gain.

Besides bi-partisan backing in Congress, the Jenkins-Keogh bill has President Eisenhower's support in principle. During the campaign in October 1952 he said: "In 1942 the Government made an important supplement to the Social Security Act by legislation which offered tax advantages to corporations and their employees in the establishment of pension funds (Section 165 of the Internal Revenue Code). . . . When this legislation was being considered, self-employed individuals were evidently forgotten. . . . I think something ought to be done to help these people to help themselves by allowing a reasonable tax reduction for money put aside by them for their own savings. . . . If I am elected I will favor legislation along these lines."

The Jenkins-Keogh bill—"The Individual Retirement Act of 1953"—proposes to help physicians, dentists, lawyers, accountants, engineers and other



self-employed professionals put aside part of their earnings for retirement. It would do so by giving them valuable tax advantages now possible only under Treasury-approved pension and profit-sharing plans for employees.

In conclusion, I urge physicians to take a moment from their busy work schedules and to write to their congressman and senators urging that self-employed professionals be not included in the amendments to the Social Security Act, as proposed in the Reed bill, and that all of us favor the enactment of the Jenkins-Keogh bill to give the self-employed professional an opportunity to save for old age and retirement out of current income.

### Report from American Bar Association

Item 20, Unemployment and Social Security. The Chair recognizes Mr. Oliver, chairman.

MR. OLIVER (Missouri): Mr. Chairman and Members of the House: Your Committee on Unemployment and Social Security desires to make what you may term a progress report. It is upon a controversial issue. There is pending in Congress at this time, House Bill No. 7199 which, in our opinion, vitally affects the legal profession. It is sponsored by the present incumbent of the White House. Similar proposals were sponsored by both of his two immediate predecessors. It is, therefore, not a partisan political issue. Its purpose is to bring within the Social Security program an additional approximately 10 million people, including all self-employed lawyers, doctors, dentists, and others within the profession.

The Social Security movement is worldwide. The initial legislation in our country was in 1935. Its purpose was to provide security at the age of 65 for the worker, then and now being retired or discharged at that age. It specifically excluded self-employed lawyers and other professions. To include them now would be to change the present status. The O.A.S.I., or Old Age and Survivors' Insurance, is the primary issue here.

Under the present Act, if you are employed for a period of six quarters, 18 months, you become eligible to payment of \$85 a month when you reach the age of 65, provided you do not earn as much as \$75 per month when you arrive at that age of 65. If you do, you do not receive any of the benefits provided by the Act. The only bargain that our Committee sees in this Act is for those members of the professions, ours and the other professions, who are

approaching the age of 65 and have definitely determined that they will completely retire at that age—there are very few of that type—and the young man who, perhaps 25 to 35 years old, is reasonably certain that he will die within the next ten years, and does. Those may be carried as bargains under the Act. There are a few of that type.

In 1950 the American Bar Association took a position, through the action of this House, approved by the Assembly, which disapproved the inclusion of lawyers within the Act. This Committee, of which I happen to be the chairman, was appointed immediately thereafter, and our Committee has consistently approved the action initially taken by this House and approved by the Assembly, which is that lawyers shall not be included within Act.

In our annual and semi-annual reports to this House, we have attempted to give the reasons for inclusion as well as the reasons against inclusion.

In the November issue of the *Journal*, there appeared a well written and well arranged article written by Dean Larson, of Pittsburgh University, giving the reasons why this profession should be included. In the January issue of the *Journal* our Committee took a position definitely giving our position, which is that we should not be included within the program.

At the Boston meeting last August the Board of Governors requested that we withdraw our report, reaffirming our position and make a further study, particularly with reference to the voluntary or elective coming within the program, giving each lawyer the right to elect or determine whether he individually be brought within the program or not.

We wrote to the president of every state bar association. We wrote to the fifty largest bar associations in the country, and we wrote to fifty of the smaller bar associations within the country. We have charted the results. I fear you cannot see them, so may I give them to you? I shall content myself with giving you only the totals, but we have here listed how each state and how each bar association that responded—forty of them—voted. We have the letters here to back up the chart.

I give now only the totals. The state associations have voted thus: Two for compulsory, four against compulsory inclusion. Under the voluntary basis, four for; four against. Not yet ready to report from the state associations, ten. Of course, the others are not yet ready to report or they would have written

us. We give only those on which we have the written evidence.

Under the large local associations: for compulsory, two; against compulsory, two; for voluntary, five; against voluntary, two; not yet ready, four.

The smaller associations: for compulsory, one; against compulsory, three; for voluntary, one; against voluntary, three; not yet ready to report, two. Total: For compulsory, five; against compulsory, nine; for voluntary, ten; against voluntary, or elective, eight; not yet ready to report, eighteen.

How your particular association is listed, appears here by name. You are welcome to examine it.

On Thursday of last week, we held a panel at this regional meeting and had a discussion which lasted one hour and forty minutes, and when our time was up we were asked to continue. The interest of those who were there was keen. There were but few present. We were honored, I believe, by two or three members of this House.

I might tell you that the personnel of the Committee which has served you included—and the personnel has been continuous during the four years of its service—the expert of the Standard Oil, the expert of the United States Steel, a vice-president and general counsel of a large insurance company in Boston; the general counsel for another insurance company; the head of the Unemployment and Social Security program of the State of New York; and two practicing attorneys, one from the largest city in the world, the other a country practitioner, your speaker. So we have had somewhat of a cross section of our Association.

Now, may I address myself to some of the basic principles involved, and I know the time is brief. Most people look at most propositions through bill-fold spectacles—the cost. We have urged and argued and pleaded for \$2 million to build a home for this Association, and haven't quite reached that amount. Yet this program, gentlemen, will cost you and the rest of the lawyers in America \$24,300,000 per year on the present rate and on the present basis of \$3,600, with the certainty that it will be increased.

May I call your attention also at this time to the fact that you get nothing out of this until you arrive at the age of 65, and you will get nothing until you arrive at the age 75 unless you make less than \$75 a month between the ages of 65 and 75.

May I also call to your attention the fact that in entering this program you are not buying an insur-

ance policy. You get no policy. You have no vested or immutable right from your government for the money which you pay in under this program. Nobody else has that pays in under this program. I have some cases on that. A recent case decided in Massachusetts cited three United States Supreme Court decisions. I shall not take time to give them to you now. I have them if you want them.

There has been built up in this fund what is called a trust fund in which there is a surplus of \$18 billions of money. I saw last year that an actuary said that if you want this plan to be carried out, it will take a trust fund, a reserve of \$200 billion. The \$18 billions which we now have has been invested in United States bonds. You may draw your own conclusion as to what will happen when you need the money. That is a controversial issue upon which I have definite ideas.

We are not opposed to the Jenkins-Keogh bill. We favor it. We think it is a good thing.

We were asked to direct our studies primarily to the question of voluntary inclusion. Let me tell you about three reasons why we are opposed, first, to compulsory and then nearly a dozen reasons why we are opposed to voluntary.

First, we are opposed to the inclusion of lawyers under the compulsory basis as provided in this 7199, because on principle we are against regimenting the profession. We are against selling our birthright from our founding fathers for an illusory mess of pottage, and it is illusory. This is not a contractual matter with the government. It is an administrative, legislative, one which they can cut off if they please. Some countries have done so.

Secondly, we are against it because of the cost. As a profession and as individuals within the profession, we will not get out of it what we put into it unless you are one of those rare cases of the bargains that I mentioned earlier. I think if you ask any competent actuary he will tell you that the plan is not sound economically.

We were asked to make a special study with a view of the voluntary or elective coming into the program. We have. The Lodge bill was that. It died a natural death in the Congress.

Now these reasons suggest themselves to us as opposed to the voluntary inclusion, that is, of letting each lawyer determine for himself whether he would come in: First, it isn't sound economically. I shall not dwell on that. It will cost each member



more than he will ever get out of it, from the selfish viewpoint. It would be discriminatory in favor of the professions. It would give you and me a privilege which our next door neighbor would not have. He wouldn't like it. It isn't good from a public relations standpoint. If we have the right, the privilege, he should have it. If he does not have it, why should we be put in the privileged class? It would cause dissension.

A member of this House said to me, "I now wish I had gone into it when I had the opportunity."

I said, "Yes, and if you had gone into it, you would wish now that you had not."

He said, "Agreed."

Whichever way you move in this matter, you will probably wish you had done the other. It will sow dissension in our opinion. If you once elect, you are in, and it is irrevocable.

It would, in our opinion, ultimately result in compulsory inclusion if we were given the voluntary or elective process now. In practice, gentlemen, in our opinion it will not work, and may I say that the opinion of our Committee is now and has continuously been unanimous through the four years that we have served you.

Finally, we find no rank and file clamor for this thing. I am frank to tell you I thought there was. I so wrote to the members of our Committee. I thought there was an upsurge from the grass roots in favor of voluntary inclusion. The chart shows I was wrong. We find no upsurge from the grass roots in favor of it.

The situation as we find it is very comparable to that which we found when we reported to you in San Francisco a year and a half ago. Some are for, some are against. In my humble opinion no lawyer worthy of the name ought to either ask or permit, if he could help it, a situation where he would be dependent upon his neighbor to take care of himself in his old age, nor his family, that any lawyer worthy of the name ought to take care of himself and of his own family and not be dependent upon the public therefor.

The Committee has not changed its position. We did not get the information that we present to you here in time to make a recommendation, and for us to make one would be out of order. We, therefore, present to you merely a progress report.

## COURT HALTS "ELECTRONIC"—Cont.

Judge John D. Clifford. Those enjoined from distributing the devices are Dr. Wilhelm Reich and his wife, Ilse Ollendorff Reich, and an alleged non profit-making corporation, the Wilhelm Reich Foundation, all of Rangeley, Maine. The decree was issued in default of contest by the defendants.

The Food and Drug Administration, U. S. Department of Health, Education, and Welfare, initiated the injunction suit. The defendants did not contest the injunction, according to the FDA, because it is Dr. Reich's contention that neither the Federal court nor the Food and Drug Administration has jurisdiction over his activities. In February 1954 Reich published a "Response" regarding this action, in which he stated: "Inquiry in the realm of Basic Natural Law is outside the judicial domain," and "I shall not appear in court as the 'defendant' against a plaintiff who by his mere complaint already has shown his ignorance in matters of natural science."

According to the decree, the defendants must recall all orgone energy accumulators now rented to out-of-State practitioners and patients, together with the labeling which misbrands them. This labeling is to be destroyed. The devices may be either destroyed or salvaged for materials of which they are made.

The injunction decree prohibits the shipping of any of the devices which is misbranded under the Federal Food, Drug, and Cosmetic Act because of any representation or suggestion in the labeling that it has value in the treatment or diagnosis of the diseases listed in the complaint or any other kind of disease, or has value in affecting any structure or function of the body; or which purports to produce low power radio waves or electro-magnetic energy, or low-frequency alternating magnetic energy which, when applied to the body, "normalizes" diseased tissue, thereby correcting disease conditions.

The Foundation, formerly the College of Electronic Medicine, was set up by the late Dr. Albert Abrams, inventor of the machines, to perpetuate his electro-medical theories. Fred J. Hart, president, has informed the Food and Drug Administration that research on the utility of the devices will be continued in Germany and Mexico, and that a magazine, *The Electronic Medical Digest*, will continue to be published.

## NEWS FROM WASHINGTON

### Reinsurance Plan Looks Like a Dead Duck

Hearings on the Eisenhower-Hobby reinsurance plan appear to have buried it a little deeper. The insurance companies are sufficiently astute to recognize that HR8356 carries enough punch, if enacted into law, to bring health and accident underwriters under Federal control. Testifying recently before the House Commerce Committee, John H. Miller, vice-president of Monarch Life Insurance Company, and Henry S. Beers of Hartford, vice-president of Aetna Life Insurance Company, commented that the reinsurance plan is noble of purpose and deserves further study. Both men agreed, however, that it would not benefit an estimated 40 billion who cannot afford to purchase health insurance coverage. Both gentlemen praised the scheme with faint damns, according to Washington reporter Gerald Gross, and Mr. Beers, when asked if the Aetna would participate provided the bill if passed, replied "Probably not."

### AMA Supports Grants Bill, But Suggests Some Changes

American Medical Association has approved the administration bill doing away with numerous categorical health grants and setting up three broad groups for grants to states. Dr. George F. Lull, secretary and general manager, wrote the House Interstate and Foreign Commerce Committee that the AMA "which has always promoted state and local health services . . . approves the bill generally," although it has reservations on some provisions and believes clarification is imperative.

The bill (HR7397) provides three types of grants: Type 1 grants to help states meet costs of public health services; type 2 grants to aid states in initiating projects for extension and improvement of services; and type 3 grants which would assist states as well as public and other non profit groups to launch special projects of regional or national significance.

The AMA proposed that types 1 and 2 grants be lumped into one category, thereby placing initial responsibility for extension and improvement of health services in the hands of the state health

officer. Other suggestions were (1) in view of "apparently unlimited authority" given the surgeon general of Public Health Service in type 3 grants, language in the act should be clarified to require the surgeon general to consult with state health authorities before making such grants, and (2) the bill should spell out percentages of total funds to be used in each category, with amounts for special "type 3" projects held to a small percentage.

Dr. Lull called attention to the work of the Commission on Intergovernmental Relations which is inquiring into grants-in-aid to states. It might be desirable, he said, to have "the benefits of its findings and recommendations in this highly important field prior to extensive legislation changing the present grant-in-aid policies and requirements."

### Social Security Hearings Opened April 1 in House

April 1 the House Ways and Means Committee opened public hearings on HR7199, the administration bill for extending social security coverage. Extension would be compulsory for 6.5 million persons, including physicians, dentists, interns, farmers and most other self employed. Coverage would remain optional for clergy and certain state employees. Other provisions would increase from \$3,600 to \$4,200 the amount of income to be taxed under OASI, permit retired persons to figure their allowable earnings by the year (\$1,000 maximum) rather than by the month (\$75), raise payments to beneficiaries, and protect ultimate pension rights of disabled persons by excluding the disability period in computing average earnings. The American Medical Association's witness testified on April 6. At its last meeting the Board, in conformity with past policy, voted active opposition to the compulsory inclusion of physicians under social security, but no opposition to voluntary coverage of physicians. The association took no position on other provisions of the bill.

### House Committee Urges "Fair Trial" for New VA Admission Policy

A resolution adopted by the House Veterans Affairs Committee outlines the committee's attitude



toward eligibility of veterans for medical care by Veterans Administration. These points are made:

1. The committee approves (a) the present unlimited hospitalization of service connected cases, (b) the continued hospitalization of nonservice neuropsychiatric and TB cases, and (c) the continued hospitalization of other nonservice cases "where beds are available and the veteran does not have the ability to pay for private hospitalization."

2. The committee urges "all veterans' groups and all other parties interested in medical care for veterans" to defer final conclusion on eligibility until the new VA admission policy "has been given a fair trial and a period of operation." Meantime, the committee recommends that no new legislation be considered on the subject of eligibility or admissions.

(In November, 1953, the VA put into effect a new 10-P10 form addendum on which the veteran applying for care of a nonservice connected condition would be asked to list his assets and liabilities. Under the law, however, VA cannot deny admission on the basis of information furnished on the form.)

In its resolution the committee notes that a subcommittee, under chairmanship of Bernard W. (Pat) Kearney (R-New York), last year conducted hearings for a month on the subject of entitlement and eligibility. The committee emphasizes that the subcommittee took testimony from veterans' groups, medical societies (including AMA) and government officials. The committee's resolution is in effect an endorsement, for the time being, of the official policy of the Veterans Administration.

The American Medical Association policy on eligibility of veterans would limit the medical care of veterans to two groups: 1. Those with peacetime or wartime service whose disabilities or diseases are service incurred or aggravated. 2. Within the limits of existing facilities, veterans with wartime service suffering from tuberculosis or psychiatric or neurological diseases of nonservice origin who are unable to pay for hospitalization. VA should care for the latter group only until nongovernment facilities are adequate to assume the responsibility. Care of other nonservice connected cases would be the responsibility of the veteran himself or the community.

## 82 Per Cent of Needy Aged "Able to Care for Selves"

A new survey by the Bureau of Public Assistance indicates that 82 per cent of the needy aged receiving

public assistance are able to care for themselves, and less than 4 per cent are bedridden. The study also found that 80 per cent of the recipients are more than 70 years of age and 25 per cent are past 80. It was determined that although most aged persons live in cities, a majority of those receiving public assistance live in rural areas.

## New Senate Legislation

**S3096—Doctor Draft Act.** (Saltonstall, R—Massachusetts, March 4.) Would remove the mandatory requirement that physicians and dentists be given commissions. They could be utilized in their professional capacities although serving in an enlisted status. This legislation was introduced at the request of the Department of Defense, transmitted in draft form with a letter from Assistant Secretary of Defense Fred A. Seaton. The Committee has scheduled a hearing for March 18. To Armed Services Committee.

## Hearings

**HR8356—Federal Reinsurance Corporation.** (Wolverton.) Secretary Hobby of the Department of Health, Education, and Welfare opened the House Interstate and Foreign Commerce Committee hearings on reinsurance (HR8356) on March 24. She stated that although the Administration believes the program holds great promise, it has the following limitations: (1) it can only help those who can and are willing to include health insurance premiums as a necessary part of the budget and those covered by employer maintained plans, (2) it "may not immediately" solve the problems of coverage for those who are now aged or chronically ill, (3) success of the plan depends on willingness of carriers to make use of the plan and to assume new and broader risks.

Mrs. Hobby said reinsurance to plans (such as Kaiser) that furnish their own medical care could be offered, provided they place control over the manner in which medicine and dentistry are practiced solely in licensed members of the profession. She also stressed that (1) the bill forbids exercise of any supervisory or regulatory control over any carrier, hospital or other facility, except as specified in the act, and (2) the program would be wholly voluntary and no individual plan would be reinsured if it could be reinsured privately.

Mrs. Hobby and committee members were in

general agreement that the legislation was, in the words of Chairman Wolverton, "pioneering in a new field of activity" and with the possible exception of Australia and perhaps one other country, the plan had never been tried before. The committee continued questioning of Administration witnesses on March 25.

### Action on Legislation

**HR8149—Amends Hospital Survey and Construction Act.** (Wolverton.) (Hill-Burton.) On March 9 the House passed this measure by a voice vote. In approving this legislation, the House altered the restrictions to allow grants to certain facilities supervised by osteopaths as well as those supervised by physicians. Otherwise the bill was the same as that reported out by the committee.

As reported out by the Interstate and Foreign Commerce Committee, grants to rehabilitation facilities, nursing homes and diagnostic and treatment centers were restricted to those operated in connection with a hospital or under the supervision of persons licensed to practice medicine in the state. Before approving this bill, however, the House amended the restriction to read "licensed to practice medicine or surgery." It was explained that the change would qualify osteopaths in 21 states who are licensed to practice "osteopathy and surgery," although not to practice "medicine." There was no change regarding hospitals for the chronically ill, which come under the definition of hospitals now in effect in the regular Hill-Burton program.

The bill now goes to the Senate Labor and Public Welfare Committee. The legislation provides an authorization of \$182 million spread over three years. Of the total, \$20 million would go for diagnostic or treatment centers and a like amount for hospitals for the chronically ill, and \$10 million for rehabilitation centers and the same amount for nursing homes. State surveys and planning would be financed by a federal grant of \$2 million.

### Tax Revisions

The House Committee on Ways and Means reported favorably to the House HR8300, the general tax revision bill for 1954. Bill allows a deduction for medical costs from taxable income if they exceed 3 per cent instead of the present 5 per cent.

Maximum limitations for medical deductions would be doubled from \$1,250 to \$2,500, multiplied by the number of exemptions, with a limitation of \$5,000 on single taxpayers and \$10,000 for heads of families or married couples filing a joint return. The annual tax loss is estimated at about \$119,000,000.

HR8300 permits costs of medicines and drugs to be included in medical expenses only to the extent the items exceed 1 per cent of adjusted gross income. At present it is generally accepted that all medicines and drugs can be included. The government expects by this change to add \$40,000,000 annually in tax money.

Transportation expenses, where travel is necessary and prescribed by a physician, could be deducted, but not the cost of meals or lodging. A decedent's medical expense also could be deducted if paid by his estate.

### Dr. A. W. Miller Commended

Rep. A. W. Miller (R—Nebraska), a physician member of the House, has been warmly commended by the House Interstate and Foreign Commerce Committee for his work in bringing the many divergent interests together on a bill for more careful control of pesticide chemicals used in agricultural products. The bill is the result of a long series of hearings, starting three years ago. Dr. Miller said the main provision of the bill requires that a tolerance be established before any pesticide can be put on the market. It also provides temporary tolerances for experimental purposes.

### Lectureship Established to Honor Dr. Bauer

The Aero Medical Association has established the Louis Hopewell Bauer lectureship in honor of the association's first president. Dr. Bauer is secretary-general of the World Medical Association and was the 1952-53 president of the American Medical Association. The honor was announced at the dinner concluding the annual meeting of the Aero Medical Association. The three-day meeting, held in Washington, was dedicated to Dr. Bauer. Dr. Kenneth E. Dowd of Montreal was named president-elect, and Brig. Gen. Otis O. Benson, Jr., took office as president. The retiring president is Rear Adm. Bertram Groesbeck, Jr.



## PHYSICIAN CONTRIBUTIONS TO THE 1954 AMEF CAMPAIGN WILL . . .

- Assure representation of the medical profession in the drive to balance medical school budgets.
- Help reap the full benefits of a system of medical education unparalleled in history.
- Encourage support from industry and other segments of our society.
- Help medical schools to maintain high standards.
- Help preserve academic freedom and maintain America's leadership in medicine.

**Your Contribution is Needed**

## PUBLIC RELATIONS

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### New Exhibit Features Emergency Plans

A new exhibit portraying the growth of emergency medical call plans sponsored by medical associations has been developed by the Society's Committee on Public Relations.

Exhibited for the first time at the recent 162nd Annual Meeting of the Society, the exhibit is nine feet wide by seven feet in height and is illuminated to indicate the location and telephone numbers of the 14 major emergency call plans sponsored by county and local medical associations. A leaflet describing the plans and the services they offer residents in sudden emergencies is available for distribution with the exhibit.

Planned to advance the story of community services sponsored by medical associations, the exhibit will be displayed throughout the state under auspices of county medical associations. Hartford County is the first county in which the exhibit will be used. It will be displayed first in the lobbies of general hospitals, later in public libraries and municipal or other public buildings.

### Physicians Sponsor Emergency Plans in Groton, Naugatuck

Physicians in two more Connecticut communities have established plans to provide prompt medical attention in sudden emergencies.

In Groton a new plan was recently inaugurated to provide emergency service principally during week-ends, while in Naugatuck a plan to provide 24 hour coverage has been announced.

Both plans have met with strong public support and town officers have commended physicians in the two areas for their contributions to community service.

The Naugatuck plan will be serviced by a panel of 11 physicians, each of the panel members to respond to emergency calls one week at a time. The switchboard of the local police headquarters will be used to receive and transmit emergency calls.

Seven physicians are enrolled in the Groton plan, and the names of those available during each week-

end will be published on lists to be posted in pharmacies, physicians' offices and business establishments. Newspaper announcements concerning both plans urge residents to use the service only in emergency and to call their own physicians first. Though limited in scope, the plans provide effective medical coverage for emergencies similar to the services of the major plans now being sponsored by medical associations in 14 large centers of population throughout the State.

### New TV Films Announced

A new series of five minute films suitable for medical association sponsorship on television has been announced by the Bureau of Health Education of the American Medical Association.

The films feature Miss Abby Lewis, character actress, supported by a competent cast, and are directed by Martin Magner. Produced especially for use in local communities, the films present useful information on health topics of special interest, including contagious diseases in the home, eating habits, home accidents, the convalescent child, and other subjects.

The films are available on a loan basis to local medical societies or to health agencies with the approval of the local medical society. The films are available without cost except for return shipping charges.

### Speakers Bureau Active

An increasing number of requests are reported for physicians to speak on the aspects of government health services before community organizations and other groups.

Two requests for programs of this type were received from university groups during April. The speaker on both occasions was Dr. D. Olan Meeker, Riverside, chairman of the Society's Committee on National Legislation. On April 5, Dr. Meeker addressed a class of students at the Waterbury branch of the University of Connecticut and on April 22 he participated in a panel discussion at Yale University, sponsored by the John Dewey Society, an undergraduate organization.



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## MILITARY AFFAIRS

### COMMITTEE ON MILITARY AFFAIRS

COLE B. GIBSON, Meriden

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#### Navy and Air Force Adopt Army's "Rushing" Scheme

Army plan by which senior dental and veterinary students may volunteer for commissioning and early active duty following graduation is being adopted by Navy and Air Force. In this instance, the invitation will be extended to this spring's classes of graduating dentists and M.D.'s completing internship. The idea is being extended notwithstanding fact that Army innovation has encountered little enthusiasm so far. To date there have been only 56 dental and 41 veterinarian nibbles, tending to indicate that quotas will not be filled (330 and 75, respectively). Probability is that deadline for applications, which had been fixed at March 31, will be pushed back. Said an Army official wearily: "Seems it's still a case with them of 'I'll hold back, maybe they'll never reach me anyway'." Meantime, Defense Department questionnaire cards have gone out to medical and dental deans in connection with the new matching plan program.

The Army has announced it will draw on Medical Corps Reserve rolls for activation of 276 physicians, beginning in July. This figure is expected to satisfy replacement needs until October. Priority I and Priority II type Reserves will fill the callup, along with such as may volunteer.

#### Procedure Set for Doctor Draft Loyalty Cases

In anticipation of passage of the amendment to the Doctor Draft act, Defense Secretary Wilson has established a policy for handling all suspected loyalty cases arising under the act. (The amendment would permit the Armed Forces to retain, in non-commissioned status but assigned to professional duties, any physician, dentist, or veterinarian whose loyalty is questioned.) If the amendment is enacted, the following procedure immediately will become

effective: (1) If questions of loyalty interfere with commissioning, an "intensive investigation" will be conducted; a 90 day limit is placed on the investigation, except in unusual cases; (2) if the man is found to be a security risk he will be "expeditiously processed out of service with an appropriate discharge," which will state that he was discharged because his retention was not consistent with the security of the United States; (3) if investigation clears the man, he will be offered a commission at the appropriate rank; (4) during the investigation, the individuals concerned will be "retained in an enlisted status and used in their professional capacity under necessary safeguards."

The proposed procedure was outlined by Assistant Defense Secretary Hannah before the Senate Armed Services Committee just before it reported out the Doctor Draft amendment.

#### Selective Service Resumes Processing of Physicians

For the first time since last August, local draft boards are again processing physicians for induction under the Doctor Draft act. Selective Service headquarters on March 25 ordered draft boards to resume processing for physical examination and induction of priority 1 and 2 physicians of all ages, priority 3 physicians born after August 30, 1922, and priority 1, 2, and 3 dentists of all ages. Selective Service explained that it expected at any time to receive an armed forces call for physicians. Calls for dentists in March, April and May already have been allocated to the states.

The government halted drafting of physicians last summer after the Korean truce and a high percentage of young physicians entering the service on completion of their internships had produced a large reservoir of medical manpower. The last call for physicians was for 542 in August.



### Hospital for Convalescent and Chronically Ill Patients

The Flora & Mary Hewitt Memorial Hospital, Inc. in Shelton has for its use the former residence of the late Edward E. and Flora Hewitt Gardner, made possible through the generosity of Mrs. Gardner's father, the late Alvin E. Hewitt. The hospital came into being as the result of a provision in the will of the late Alvin E. Hewitt, who left a considerable sum of money in trust for his daughter, with the provision that at her death its income might then be used "to establish and support a non-sectarian hospital for the furnishing of medical and surgical care to the residents of Shelton and vicinity without regard to their nationality, creed or belief."

Following Mrs. Gardner's death, several interested citizens, under the leadership of Mrs. Arthur Cochran, organized a nonprofit corporation designed to establish and operate such a hospital, and were recognized by the Hewitt Trust Fund as acceptable to receive interest from the fund for the carrying

out of this purpose. The original incorporators were Mrs. Arthur Cochran, president; William R. Todd, vice-president; Edward L. Miller, treasurer; Miss Josephine Sullivan, assistant treasurer; Dean A. Emerson, secretary; George H. Gamble, Sr., Raymond P. Lavietes, Philip J. Franz, Edward N. Secombe, Ludolph H. DeWyk, Jr., Adam A. Bogan and Fred M. Daley, directors, and who now serve as the board of trustees.

Following a survey plans were drawn up and eventually completed. The capacity of the new hospital is 29 beds with recreation rooms, all modern facilities, and a complete new kitchen. All laboratory and x-ray work will be taken care of by the Griffin Hospital. The purpose of the Flora and Mary Hewitt Memorial Hospital, Inc. is to provide adequate convalescent and chronic care to patients, preference being given to residents of the lower Naugatuck Valley.



## FROM OUR EXCHANGES

McQuarrie in his foreword to "A Symposium on Potassium Metabolism" (*Jour. Lancet*, 73:5 and 6) calls attention to the fact that experimentation in the field of potassium metabolism has been immensely facilitated by the availability during recent years of radioactive isotopes and flame photometry. As a result, data has accumulated at an inordinate and confusing rate. There is an attempt in this symposium to bring the story of potassium metabolism together. The essential physiological roles and the clinical significance of body potassium begins to emerge in this series of some thirty contributors. There is no doubt but that the clinician who is charged with the regulation of the electrolyte balance of the body for the preservation of health is contending with an extraordinarily complicated situation where many conflicting influences contribute to confuse the explanation of the effects observed.

A study of this series of articles may not make the roll of potassium metabolism in controlling the body functions in health and disease clear to the average physician but it will at the very least be informative.

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Whitehead in 1939 made the statement that "Fifty-seven years ago it was when I was a young man in the University of Cambridge I was taught science and mathematics by brilliant men and I did well in them; since the turn of the century I have lived to see every one of the basic assumptions of both set aside; not, indeed, discarded, but of use as qualifying clauses instead of major propositions; and all this in one life span—the most fundamental assumptions of supposedly exact sciences set aside." Dr. Whitehead goes on to wonder if we can write "Now at last, we have certitude—when some of the assumptions which we have seen upset had endured for more than twenty centuries."

This quotation from Dr. Whitehead was induced by a glance through the Fiftieth Anniversary issue of *The Journal of the Medical Society of New Jersey* (50:9). Taken in conjunction with the "Symposium on Potassium Metabolism" it is obvious that Dr. Whitehead's observations on pure science are equally applicable to what has happened in medicine,

not only in the field of medical science but also in the area of medical practice. The superior doctor of fifty years ago, if he could return, would discover very little in clinical practice that would have the face of a familiar method in dealing with health and sickness. Obviously the doctor must be prepared for many changes in his practice during the coming years for medicine in no field is today static.

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According to Dennis (*Miss. Val. Med. Jour.*, 75:4) syphilis is a vanishing disease. The use of penicillin in the treatment of early syphilis is likely to eliminate the disease in the peoples of all civilized countries. The primary lesion and secondary eruption will be seen so rarely that they will cause intense interest when seen. The prepenicillin syphilitic individual may reach the age of three score and ten because of its use.

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Cutler et al. attempted a "Clinical Evaluation of Isoniazid in the Treatment of Tuberculosis" (*Ann. of Int. Med.*, 39:3). In their experience Isoniazid is an effective antituberculosis drug. It is their opinion that in tuberculosis meningitis it is probably superior to streptomycin. In caseocavernous pulmonary or extrapulmonary tuberculosis, INA is probably less effective than streptomycin. The therapeutic response of basal pulmonary tuberculosis to INA is less dependable and more variable than to streptomycin and PAS. The authors discovered evidence of a "dissociated therapeutic action" of INA. This dissociation consisted of simultaneous resolution of one lesion with progression of another. On theoretic ground the authors concluded that there was strong support for the simultaneous use of streptomycin, PAS and INA.

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"The Danger of Peptic Ulcer Complications During Cortisone or ACTH Therapy" is noted by Edwards and Wollgast (*Rocky Mt. Med. Jour.*, 50:9). They report on a case of acute perforation of a gastric ulcer during ACTH and cortisone therapy. The authors call attention to the masking effect of these hormones and suggest that precaution be exer-

cised in the use of these drugs. It has become a fairly well established fact that cortisone and ACTH therapy are dangerous in the presence of peptic ulcer.

\* \* \* \*

"A Complete Stripping of Varicose Veins Under Local Anaesthesia" is the method of treatment favored by Nabatoff (*N. Y. State Jour. Med.*, 53:12). His reasons are briefly summed up under the following headings:

1. Complete stripping of varicose veins in his practice was carried out routinely under local anesthesia. This procedure permits almost immediate postoperative ambulation, which greatly minimizes the danger of thromboembolic complications.

2. In a great majority of the patients four incisions were made: in the groin, mid thigh, just below the knee, and just above the ankle. At these sites all communicating veins, competent or incompetent, were ligated and divided.

3. All other incompetent perforator veins were accurately mapped out preoperatively, and these were also ligated flush with the deep system prior to the stripping procedure.

4. Since all incompetent and competent perforator veins communicating with the diseased great saphenous system and all "blow-outs" in other locations were interrupted, and since the remaining varicose veins segments were stripped out, very few, if any, injections of sclerosing solutions were needed following the operation.

\* \* \* \*

"The Boric Acid Problem" is a matter of timely concern (Brooke, *G.P.*, VII:6). An appreciation of the potential toxicity of boric acid when applied to the skin is important. There have been reported a number of cases of serious or fatal poisoning resulting from the transcutaneous absorption of boric acid when applied to wounds or dermatoses. The clinical diagnosis of boric acid poisoning is not difficult if the physician is aware that it can occur and is familiar with the clinical signs. It is often confused with severe gastroenteritis, infectious diarrhea, septicemia, pneumonia and meningitis by those not familiar with the clinical picture. The diagnosis of boric acid poisoning should be considered in any infant who has diarrhea and vomiting associated with a diaper rash. It takes only a few seconds to ask a mother what she has been using on the diaper rash.

The reply may result in saving the baby's life. The diagnosis is made simple in a severely poisoned infant by the appearance of an intense erythema of the skin, mucus membrane, and tympanic membranes, followed by superficial desquamation a few days later.

Treatment is supportive since no antidote is known for boric acid poisoning. Oxygen, blood, intravenous fluids and antibiotics to prevent the development of bronchopneumonia are the mainstays of therapy.

\* \* \* \*

"Hand Injuries—The Immediate Treatment of Acute Open Wounds" demands a great deal of the surgeon who undertakes it (Mason, *Indus. Med. and Surg.*, 22:9). In cases of extensive wounds the difficulties usually arise from error in initial care, most important of which are (1) extensive primary repair in a wound under conditions unsuitable for such care; (2) retention of nonviable skin flaps which slough in a few days with resultant serious disturbance in healing; (3) failure to close the wound at all; (4) failure properly to splint the hand.

Minor wounds of the hand are taken more seriously today than they were 20 years ago and few people escape the penicillin needle. The initial care of hand wounds may, in the majority of instances, be the final and definitive care even in quite extensive wounds. Occasionally, however, the initial care of wounds of the hand may be only the first stage of repair, even in seemingly simple wounds.

The greatest enemy to successful surgery of the hand is scar tissue. It is for this reason that every effort should be made to minimize delay and disturbance in healing, to protect against secondary contaminants, and to secure prompt and reactionless healing by closing wounds of the hand primarily. It should be added that there are obviously some situations in which primary closure is not possible or feasible, but they are rare in civilian practice.

Prognosis as regards function cannot be determined in many cases immediately. This is especially true of nerve and tendon repairs. Improvement often goes on over a period of three to five years, and this is not just an increase in dexterity which a patient with a disabled hand develops. There is an improvement in tendon motion and a nerve recovery that progresses slowly and almost imperceptibly.



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## OBITUARY

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**George H. Dalton, M.D.**

**1891 - 1953**



The long and distinguished career of Dr. George H. Dalton came to an end on November 20, 1953 after a long illness. Death came to him at the New Britain General Hospital two days after his admission there.

George Dalton was born on April 22, 1891 at New Britain, the son of the late James and Rose (Flood) Dalton. He was a life-long resident of that city and was graduated from St. Mary's School and New Britain High School. After receiving a bachelor's degree from Yale University, he received his medical degree in 1912 from the Yale Medical School and began practice in New Britain in that year.

Dr. Dalton was attending physician at New Britain General Hospital from 1920 to 1945, and formed the medical staff at New Britain Memorial Hospital when it opened in 1941. He served as president of that institution's medical staff from 1941 to 1947.

During World War I Dr. Dalton served two and a half years with the Army Medical Corps, returning to civilian life as a captain. While in France he was cited by the French government for his service to French soldiers. After the war he was named division chief of staff of the Veterans of Foreign Wars, and in 1921 was appointed post surgeon in Hartford for the Connecticut State Guard. He also served as president of the New Britain Medical Society. In 1949 he became a judge on the rating board of the Veterans Administration in Hartford, a post he held at the time of his death.

Besides membership in Walter J. Smith Post, VFW, Dr. Dalton was a member of Eddy-Glover Post, American Legion; Daly Council, Knights of Columbus; St. Francis of Assisi Church; Yale Club; Foresters of America; and the Red Men.

The community and the medical profession have suffered a great loss in the passing of Dr. Dalton. His contribution to the practice of medicine in New Britain was outstanding.

J. E. Darrow, M.D.

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### American Heart Association

At the recent meeting of the American Heart Association held in Chicago H. M. Marvin, president of the Connecticut State Medical Society, was elected to the Board of Directors as a director at large for three years. William W. L. Glenn of the Department of Surgery, Yale University School of Medicine, was chosen for a one year membership on the Assembly, the governing body of the American Heart Association. Ira V. Hiscock, director of the School of Public Health, Yale University, was also chosen for a one year membership on the Assembly as a representative of the Council on Community Service and Education of the National Association.

Representing Connecticut on the Assembly at this 1954 meeting were Philip Berwick of Moodus and William Lahey of Hartford.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Dewey Katz, Hartford*  
*President-Elect, Mrs. Newell W. Giles, Darien*  
*Second Vice-President, Mrs. Winfield Kelly, Norwich*

*Recording Secretary, Mrs. Walter Nelson, Cromwell*  
*Corresponding Secretary, Mrs. Stevens J. Martin, Hartford*  
*Treasurer, Mrs. Norman J. Barker, Collinsville*

#### REPORT OF PRESIDENT OF AUXILIARY TO HOUSE OF DELEGATES

Dr. Gildersleeve, Dr. Marvin, Members of the House of Delegates of the Connecticut State Medical Society:

The motto of the County, State, and National Medical Auxiliaries for this year has been "Together We Progress." Keeping in mind the objectives of our State organization, an organization which numbers 1,170 members today, I shall attempt to report to you how we have succeeded this year in "Progressing Together."

Our first objective is to assist the Connecticut State Medical Society in its program to advance Medicine and Public Health and to promote mutual understanding with the lay public.

#### TODAY'S HEALTH

To help accomplish this objective we have promoted, by various means, the AMA publication, *Today's Health*. We have secured a 35 per cent increase in subscriptions this year over that of last year. A great measure of credit for this accomplishment goes to the diligent efforts of the *Today's Health* Committees in Hartford and Middlesex counties. Literally, hundreds of free sample copies of *Today's Health* were distributed by members of our County Committees at various educational meetings and fairs held throughout the State. By this method many new readers were introduced to the most authentic source of health information written for the lay person. At the request of a Y.M.C.A. director, every Y.M.C.A. reading room in Connecticut was provided by the Auxiliary with a year's gift subscription of *Today's Health*. We thank you for the credit points which the Auxiliary received as a result of the gift subscriptions sent by the State Medical Society to all our Congressmen. In promoting *Today's Health* we have been assured that our efforts in this direction have been well spent by none other than the president of the AMA, Dr. McCormack, who said, "You are doing a grand thing, because you are helping in a public relations effort that means much to the preservation of private enterprise in medical care." The fact that only 15 per cent of the physicians subscribe to *Today's Health* discourages us at times. We, however, shall continually strive to increase this percentage figure and we hope that in the near future a copy of this magazine will be found in its rightful place, that is, in the waiting room of every physician. We do not feel that this is too much to hope for. An effort has also been made this year to interest the pharmacists of Connecticut in *Today's Health* in order to make this magazine saleable to the public in the drugstores. This project has been started in Windham County.

#### HEALTH EXHIBITS

We assisted the Connecticut State Medical Society in its program to advance Public Health by manning the Society's Health Exhibit at the Rural Fairs, which exhibit was under the direction of Dr. Norman Gardner and his committee. Next fall, through the cooperative efforts of both our organizations, we shall be able to distribute for the first time, to the people attending these fairs, our own "First-Aid" chart together with the usual health educational materials.

#### NUTRITION COUNCIL AND SCHOOL HEALTH

We cooperated in a statewide meeting of the Connecticut Nutrition Council for Elementary School Teachers. This was an instance when the Medical Society felt the Auxiliary's School Health Committee could do another specific job for it. Therefore, with your consent, we assisted the Connecticut Nutrition Council in financing this project and, with Mr. Burch's assistance and that of our *Today's Health* Committee, set up an exhibit of health educational value. The Chairman of our School Health Committee and the Auxiliary's president took active parts in the meeting. We consider this project of our combined organizations a valuable public service through health education. Also through the efforts of our School Health Committee we have continued to stimulate the formation of and interest in School Health Councils. To date, we are cognizant of only seven such councils in the State of Connecticut.

On the county level Auxiliaries have assisted you in conducting diabetic detection drives, manned medical information travel booths, and helped in the distribution of literature to the communities concerning your Emergency Medical Plan program.

With your consent we have become a charter member of the newly formed Advisory Council on School Health. The president of the Auxiliary served as chairman of this organization's committee on by-laws. Also with your consent we are a member of the Connecticut Health League. We continue to be a contributing member to the World Medical Association.

#### NURSE RECRUITMENT AND SCHOLARSHIPS

We have attempted individual preparedness through personal education in our Mental Health, our Legislative, and Civil Defense Committees. We have assumed community responsibility for establishing Red Cross classes and teaching Civil Defense preparedness, and in helping to stimulate Nurse Recruitment. Nursing scholarships were given in five of our seven organized counties. There were eight nursing scholarships awarded in 1953. Three medical student scholarships amounting to \$800 were also awarded by the



Woman's Auxiliary to the Hartford County Medical Association. The Auxiliary continues with nurse recruitment and the establishment of "Future Nurses Club" in whatever areas they are needed.

#### CONGRESSIONAL LEGISLATION

National legislative matters, such as SJR1, The Bricker Amendment, HR8356, (Wolverton) Health Reinsurance Fund, S2759, To Amend the Vocational Rehabilitation Act, S2778 and HR7397, Public Health Service Grants-In-Aid, HR3706, Legislation to End Discrimination of Doctors and Dentists Draft, HR7199, Social Security Extension, and legislation concerning medical care of the American Veteran were studied in discussion groups in the various counties. No definite action was taken at any time because we felt further study was necessary or because, as in the case of the Bricker resolution, we did not feel fully satisfied with available information.

#### MEDICAL AND SURGICAL SUPPLIES

After careful reinvestigation, wherein we learned that the need was great, we decided to continue our Medical and Surgical Supplies project. Through cooperation from the Connecticut Red Cross, we were able to cut the cost of carting 135 large cartons of these collected supplies to New York to a minimum. Plans for next year include, at no additional cost to this project, the shipping to foreign medical schools, through "The Darien Book Plan," those medical books and magazines which you will wish to contribute.

#### MEDICAL EDUCATION FUND

Because we believe wholeheartedly in every form of academic freedom and, as physicians' wives, believe it a duty to protect our medical schools from any abuse of such freedoms, I am pleased to report a pledged contribution for the American Medical Education Foundation from each of our seven organized counties. The contributions pledged totalled \$1,045. This together with \$200 from our State Auxiliary means a contribution from the Woman's Auxiliary to the Connecticut State Medical Society of \$1,245 for 1953 to the American Medical Education Foundation.

These have been some of our activities and accomplishments which have enabled us to fulfill our first objective.

Our second objective, To Coordinate and Advise Concerning Activities of County Auxiliaries, was carried out by conducting six board meetings, one executive board meeting, a School of Instruction, a semi-annual meeting, and tomorrow our annual meeting. The president attended, at least once, a regular meeting in every county and was the guest speaker on the program in six counties.

#### SCHOOL OF INSTRUCTION

The Annual School of Instruction, which was held in Hartford on June 9, 1953, was an important factor in the fulfillment of our second objective. Forty-five members of the Auxiliary attended. At the morning session, Dr. William M. Shepard of Putnam, then a member of your Advisory Committee, spoke to the group on the World Medical Association. Round table discussions were conducted by the Auxiliary president, State officers, and State chairmen for the county officers, and committee chairmen. Literature of

all types from the American Medical Association was used and distributed. Dr. Norman Gardner, chairman of the Connecticut State Medical Society's Committee on Rural Health, Mr. James Burch, your Public Relations secretary; and Mrs. Helen Bensché, woman's coordinator of women's activities of the State Civil Defense office, were present to furnish information in their fields. It was the enthusiastic consensus that this meeting was most helpful to county personnel.

#### CONNECTICUT QUARTERLY

To further fulfill our second objective, the Woman's Auxiliary page in the CONNECTICUT STATE MEDICAL JOURNAL has carried reports and programs of state and county activities of the Auxiliary each month. Newspaper releases and photographs concerning Auxiliary meetings have appeared in county and city newspapers. Four issues of the *Connecticut Quarterly* published by the Woman's Auxiliary have already been published this year and a fifth is in the process of publication. Copies of this *Quarterly* were sent to each State member, other State Auxiliary presidents, editors of other Auxiliary bulletins, and to members of the American Medical Association at the national office. We continue to be most grateful to the Connecticut Medical Service for their paid advertisement, which in great measure makes possible the publication of this *Quarterly*.

#### MEMBERSHIP

The state and county treasurers and the membership chairmen have worked diligently in keeping membership lists up to date and accurate for mailing, for appearance in the August issue of the CONNECTICUT STATE MEDICAL JOURNAL, and for the collection of dues. However, in spite of an increase of 79 members, we did not attain our goal of a 10 per cent increase in membership. As in the past, we again urge you to encourage your wives to become affiliated with the Auxiliary.

#### SURPLUS FUND

In order to strengthen our financial status, which you know has been satisfactory, it was voted at our semi-annual meeting to establish a "Surplus Fund," the monies to be put into a savings account, the amount each year to be decided upon by the finance committee and approved by the board of directors.

#### AT AMA AUXILIARY MEETING

Under this heading of our second objective might also be mentioned the facts that (1) the president headed the Auxiliary's delegation to the thirtieth Annual meeting of the Woman's Auxiliary to the American Medical Association held in New York City on June 2-4, 1953, and (2) with the president-elect she attended the tenth annual mid-year conference held in Chicago on November 9-11, 1953. At this conference the president was a member of the Civil Defense panel, discussing the subject assigned to her, "What can the Woman's Auxiliary to the American Medical Association do to counteract the existing apathy of the physician toward Civil Defense?"

We of the Connecticut Auxiliary now stand ready to assist you and, in fact, are most anxious for positive action in any phase of medical Civil Defense that may be necessary.

## ART AND MUSIC

Our third objective, that of Cultivating Friendly Relations and Promoting Mutual Understanding Among Physicians' Families was accomplished in many ways, among which may be mentioned the Art-Musicales held for the second year in the Avery Court of the Wadsworth Atheneum in Hartford last month under the cosponsorship of our societies. It was again an enjoyable experience for those members who attended. As has been the custom for a number of years now, plans are being made for the Annual Art Exhibition which will take place April 27, 28, 29 at the Bulkeley High School in connection with the annual meeting of your society. We hope in future years to be able to combine the Art-Musicales and the Annual Art Exhibition for physicians and their families into one event.

On the county level were held musicales, dances, rummage sales, and card parties, at which time monies were raised for our nursing and medical scholarships and for the American Medical Education Foundation, and for various public relation welfare projects carried on by the counties.

## TENTH ANNIVERSARY

During the semi-annual meeting, our tenth birthday anniversary was celebrated. We had the pleasure of having as our honored guests our national president, Mrs. Leo J. Schaefer of Salina, Kansas, and our national first vice-president, Mrs. Robert Flanders of Manchester, New Hampshire. Some of you who attended this meeting expressed surprise to see so many national officers in attendance. May I say for the record that, because Connecticut has had a national vice-president and several of our members have held regional chairmanships on the national committees of *Today's Health*, membership, legislation, and public relations, that we feel friendly and close to the members of our national organization. Working together makes for friendly relations and mutual understanding.

Through the untiring efforts and patience of the chairman of our Medical Advisory Committee, Dr. Thomas M. Feeney, we have made a decided effort this year to work closely with chairmen of the Medical Society having committees similar to those of the Auxiliary, so that "Together We Might Progress." For any progress we might have made, we are indeed indebted to these physicians for their cooperation.

I wish especially to thank Dr. Thomas M. Feeney, Dr. Stanley B. Weld, Dr. Creighton Barker, Mr. James G. Burch, and each member of my Board of Directors for their able assistance and advice during the year of my presidency, April 28, 1953 to April 28, 1954.

Respectfully submitted,  
T. Sylvia Pitzele Katz

## Breast Cancer Diagnosed Earlier

Of the Connecticut women with breast cancer there has been an increasing proportion entering Connecticut hospitals while the disease is still localized. It is a known fact that cancers diagnosed early

have a better chance for cure than do cases diagnosed at a later stage of disease. There have been 7,058 women with cancer in the breast who have been admitted to hospitals reporting to the Connecticut Cancer Register maintained by the Connecticut State Department of Health in the sixteen years from 1935 to 1950. Thirty-six per cent of the patients reported in the five years between 1935 and 1939 had localized cancers in the breast; in the six years between 1940-1945 almost 43 per cent had localized cancers; and in the five years between 1946 and 1950 almost 45 per cent had localized cancers. Therefore, the proportion of cases coming to diagnosis at an early stage of disease has increased by almost 25 per cent between the first five years of the Connecticut cancer control program and the last five years for which statistics are available.

In the sixteen years between 1935 and 1950 there were 7,058 cases of breast cancer in women in Connecticut in contrast to 97 breast cancers in men for the same period. This represents a ratio of 73 women to each man with breast cancer. There was an average of 441 cases a year in women. The highest number diagnosed in a single year was 592 in 1949 with the lowest number (259) diagnosed in 1935. There was an average of six cases a year in men with the highest number (13) appearing in 1941 and the lowest number (2) being diagnosed in 1948.

During the sixteen year period the percentage of cases in women with regional involvement has remained almost the same—an average of almost 45 per cent. A substantial drop has occurred in the percentage of breast cancers diagnosed with remote metastases. In the five years from 1935-1939 almost 12 per cent had remote metastases while only six per cent had late cancer in 1946-1950. Cases coming to diagnosis with the stage of disease not known also showed a drop in the percentage of cases. There was 6.5 per cent in 1935-1939 and 3.9 per cent in 1946-1950.

The percentages in each stage of disease among the males are based on small numbers which cause wide fluctuations in percentages with only a small change in the actual number of cases. With this limitation kept in mind, it can be seen that the percentage of cases with localized cancer and stage of disease unknown increased, while the percentage of cases with regional involvement and remote metastases decreased.



## SPECIAL NOTICES

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

May 6

"Government in Medicine—The Basis in Law"

Sidney Shindell, M.D., LL.B.

May 13

"Superficial Mycotic Infections of the Skin"

Charles N. Sullivan, M.D.

May 20

"Clinicopathological Conference"

Paul M. Sherwood, M.D.

May 27

"Some Aspects of Gastric Carcinoma"

Daniel Marshall, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room.

### SESSION ON LEGAL MEDICINE AT SAN FRANCISCO MEETING, JUNE 24, 1954

In recognition of the growing importance of the many situations in which medicine may contribute to a clarification of medicolegal issues and of the interest and concern of physicians in such situations, there will be presented at the San Francisco meeting in June a Session on Legal Medicine in the Section on Miscellaneous Topics of the Scientific Assembly. This Session will be held under the immediate sponsorship and direction of the Committee on Medicolegal Problems which has arranged an informative program to include discussions on topics of practical value to practitioners who, whether they like it or not, will some day become personally concerned in a medicolegal involvement. The following papers will be presented:

Advice to the Medical Witness

W. I. Gilbert, Esq., president, Los Angeles Bar Association

Malpractice, an Occupational Hazard

Louis J. Regan, M.D.

Medicolegal Problems Related to Sterilization, Artificial Insemination and Abortion

J. W. Holloway, Jr., Esq., and Edwin J. Holman, Esq.

Prevention of Transfusion Accidents

Alexander S. Wiener, M.D.

Legal Aspects of Medical Partnerships

George E. Hall, Esq.

Trauma, Stress and Coronary Thrombosis

Alan R. Moritz, M.D.

This Session represents a practical and somewhat new approach to a solution of some of the situations in the medico-legal field that have caused, or that in the future may cause uncertainty and possible embarrassment on the part of the physician. The program has been carefully arranged with that objective in mind and a physician will find much of value in the six papers. The meeting will be held on Thursday morning, June 24, in the White Room of the Masonic Temple located at 25 Van Ness Avenue and will begin at 9:00 A. M. and conclude at 12:00 noon.

### SECOND WORLD CONGRESS ON CARDIOLOGY

The Second World Congress on Cardiology and the 27th Scientific Sessions of the American Heart Association will be held in Washington, D. C., September 12 to 17, 1954. This will be the first international medical gathering of its kind ever held in the United States.

### WATERBURY HOSPITAL

#### WATERBURY HEART ASSOCIATION

Present a Heart Symposium at the Waterbury Hospital  
Thursday, May 6, 1954—11:30 A. M. to 1:30 P. M.

I—"Some New Concepts of Hypertension"

George A. Perara, M.D., assistant professor of medicine, Department of Medicine, College of Physicians and Surgeons, Columbia University

II—"Pathological Aspects of Hypertension"

Levin L. Waters, M.D., associate professor of pathology, Yale University School of Medicine

III—"The Use of Hypo-Tensor Drugs"

Edward D. Freis, M.D., Department of Medicine, Georgetown University Medical School, Washington, D. C.

### CONNECTICUT TRUDEAU SOCIETY

The regular Spring Meeting of the Connecticut Trudeau Society will be held at Cedarcrest, Newington, on Wednesday, May 26, 1954, at 8:00 P. M.

Dr. Maurice B. Strauss, chief, Medical Service, Veterans Administration Hospital, Boston, Massachusetts, will discuss "Metabolism and Fluid Balance as it Effects the Thoracic Surgeon, the Cardiologist, and the Internist."

Members and interested physicians are cordially invited to attend.



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## NEWS

### *from County Associations*

#### Fairfield

David T. Monahan of Bridgeport is the author of "Peptic Ulcer" published in *The New England Journal of Medicine*, December 17, 1953.

#### Hartford

The March 1954 issue of the State of Connecticut Labor Department's *Monthly Bulletin* carried a three page account of John N. Gallivan's citation for outstanding service to the physically handicapped together with an excellent illustration of the principals involved, Drs. Gallivan and Gildersleeve, Mr. John L. Connors and Mr. Arthur V. Geary.

John C. Leonard, director of medical education at the Hartford Hospital, is the author of "Program for Graduate Training in Nonuniversity Hospitals: The Hospital Viewpoint" published in the Council on Medical Education and Hospitals Section of *Journal of American Medical Association*, April 3, 1954.

Mr. C. Joseph Stetler, secretary of the AMA's Committee on Legislation and National Emergency Medical Service, was guest speaker at HCMA's 162nd annual meeting, Tuesday, April 6, at the Hartford Club. One hundred sixty-five members attended to hear him speak on national legislation affecting the medical profession.

Mr. Stetler was recently named by former President Herbert Hoover as a special consultant to the Medical Services Task Force of the Commission on Organization of the Executive Branch of the government. He will direct the staff activities of the Subcommittee on Emergency Medical Planning. (The Medical Task Force will transmit to the entire commission its findings on duplication of government activities in the medical field.)

Dr. Donald R. Morrison of Hartford was chairman of the arrangements committee for the seventh annual Cancer Conference for Physicians in New Haven this month. The conference discussed current advances in the Papanicolaou technique for cancer.

"Recent Progress in Cancer Research and Con-

trol" was the topic of Dr. Merrill B. Ruinow's talk at an organizational meeting of the American Cancer Society, Manchester Division, last February.

Dr. John I. Nurnberger of the Institute of Living spoke at a meeting of the Wheelock College Club of Hartford in March. Dr. Norman Gross spoke to teenagers at the Jewish Community Center of Hartford.

Dr. John C. White, president of the Connecticut Heart Association, was among the participants at a Hartford Heart Association meeting last March to raise funds for the association.

The National Office Management Association heard Dr. John Donnelly, clinical director of the Institute of Living, in March. He spoke on "Psychiatry and Its Role in Industry."

A symposium at the Worcester Memorial Hospital featured a talk by Dr. Edward G. Deming on the cleft palate.

\* \* \* \*

New president of HCMA is Dr. Amos E. Friend of Manchester. Dr. Friend is an eye, ear, nose and throat specialist, a member of the American Academy of Ophthalmology and Otolaryngology, and last year served as vice-president of HCMA.

Dr. Thomas M. Feeney of Hartford is vice-president. Dr. Feeney is a urologist and is the present chairman of the Board of Directors.

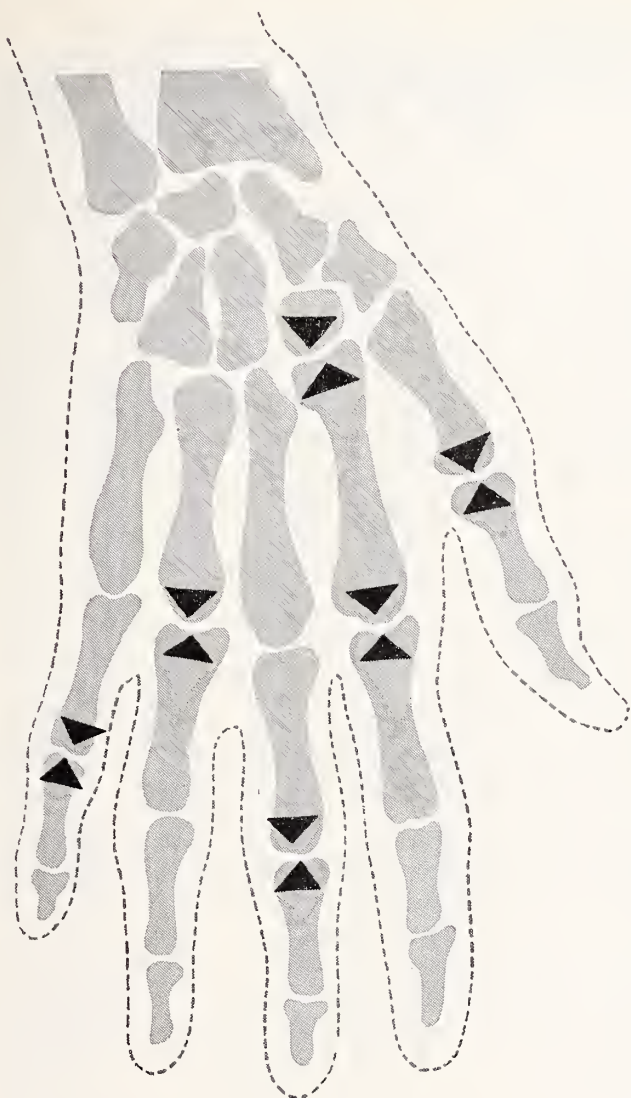
Dr. Philip M. Cornwell of Hartford was elected secretary-treasurer. Dr. Cornwell is also a urologist, and last year served in the same capacity as secretary-treasurer.

Dr. Harold M. Clarke of New Britain is alternate councilor of HCMA now. Dr. Clarke is a surgeon and former president of the New Britain Medical Society.

As delegates (and members of the Board of Directors) the following were elected: Dr. Samuel Donner of Hartford, an internist; Dr. Herman W. Winters of Bristol, a surgeon, and Dr. Samuel H. Cohn of Hartford, a surgeon also.

The Board of Directors of HCMA has voted to endorse the polio vaccine program proposed by the National Foundation for Infantile Paralysis and the State Department of Health. However, the Board pointed out that it is possible that no benefits may be "derived from the vaccine and that hazards may be involved."

(Continued on page 480)



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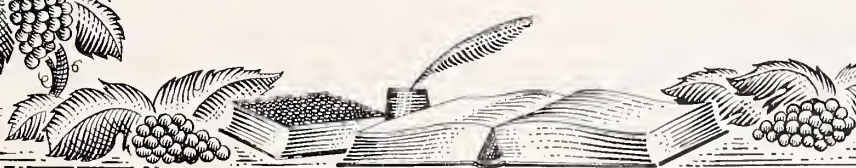
In anorexic patients, the prescription of such wine in moderate amounts has quickly brought a significant rise in caloric intake and a welcome increase in body weight.

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Along the same lines, the Board gave Dr. Burdette J. Buck authority to appoint a communicable disease committee (including polio) to assist and guide individual physicians, hospital staffs and others in the diagnosis and treatment of communicable diseases.

### Litchfield

The board of directors of the Litchfield County Hospital in Winsted voted to erect a new \$800,000 hospital adjacent to the present structure. The new hospital will contain 70 beds and will be built on the south side of the present 50 bed hospital, now 50 years old.

### Middlesex

Irving Holley, who was on the staff of the Connecticut State Hospital for over twenty years, died at the age of 82 in Middletown.

John Korab attended the annual meeting of the American Heart Association in Chicago early in April.

Harold Speight and F. Erwin Tracy attended the annual meeting of the American College of Physicians held in Chicago the first week in April.

The Middlesex County Medical Association held its annual meeting at the Commodore MacDonough Inn, Middletown, on Thursday, April 8. Our guests were G. H. Gildersleeve, president of the State Society; Thomas Danaher, president of the Council; Creighton Barker, executive secretary; James Burch, director of publicity; Stanley Osborn, State commissioner of health. Election of officers for the coming year was held, with the following results: President, Christie McLeod; Vice-President, Willard Buckley; Clerk, Vincent J. Vinci; and Councilor, F. Erwin Tracy. Four candidates were elected to membership. The speaker of the evening was Sidney Shindell who is chairman of the State Commission for the Chronically Ill. He gave an enjoyable and illuminating talk on "Legal Aspects of Medical Practice."

### New Haven

David M. Little, Jr, attending anesthesiologist at Grace-New Haven Community Hospital and assistant clinical professor of anesthesiology at Yale University School of Medicine, now on leave of absence at Great Lakes, Illinois, is the author of "Modern Balanced Anesthesia" published in the *Journal of the Medical Association of Georgia*, March 1954.

The New Haven Medical Association meeting on April 7 was addressed by John W. Streider on "The Surgical Management of Pulmonary Metastatic Disease." Dr. Streider comes from the Department of Surgery, Massachusetts Memorial Hospital, Boston. On April 21 at the New Haven Medical Association James L. Poppen, Department of Neurosurgery, Lahey Clinic, Boston, spoke on "Subarachnoid Hemorrhage and Its Treatment." The Woodward Lecture of the Yale Medical Society was given on April 5 by Dr. Andre Lwoff, chief, Department of Microbial Physiology, Pasteur Institute, Paris, France. Dr. Lwoff was educated at the University of Paris and has done postgraduate work at Heidelberg and Cambridge Universities. He has been a Dunham Lecturer at Harvard. His early investigative work has been concerned with microbial nutrition. His recent activities have been in the field of bacterial viruses, where he has worked on lysogenic bacteria, particularly on the induction of latent inactive viruses into mature infectious particles.

Daniel Levy of New Haven, president of the Grace-New Haven Hospital staff, was recently elected president of the New Haven County Medical Association.

### New London

The 162nd annual meeting of the New London County Medical Society was held on April 1, 1954. Isadore Hendle presided. New officers for the coming year were elected as follows: President, John Suplicki, Norwich; Vice-President, Eric Blank, New London; Secretary-Treasurer, William Murray, New London; Board of Trustees, Harold Bergendahl, Norwich, and Roger Fowler, Mystic.

Delegates to State House of Delegates: H. Peter Schwarz, Norwich; Malcolm Ellison, John Brosnan, William Murray, all of New London; Sidney Drobnes, Norwich; 1st Alternate, H. Von Glahn, Old Lyme; 2nd Alternate, Maurice Moore, Norwich.

Delegates to County Associations: Hartford, Lewis Sears, Norwich; New Haven, Willard Morse, New London; Tolland, H. Von Glahn, Old Lyme; Fairfield, Roger Ryley, Mystic; Litchfield, Kurt Oppenheimer, Norwich; Middlesex, Thomas Soltz, New London; Windham, Frank Miselis, Montville.

At the Scientific Session of the annual meeting of the county the speaker was David Kramer, associate professor of medicine at Jefferson Medical College.

A circular seal with a dark background and white text. The text reads "ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS". The seal is centered between two horizontal lines with decorative dots at the ends.

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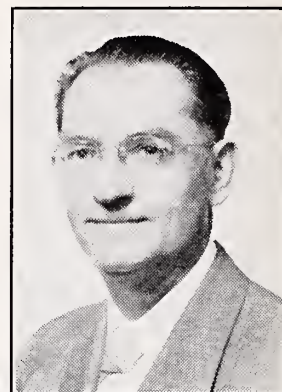


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**Joseph Juneman**



He spoke on the "Diagnosis and Management of Gangrene."

The monthly dinner lecture meeting of the Lawrence and Memorial Associated Hospitals was held March 18. The speaker was S. Charles Kasdon, assistant clinical professor of gynecology, Tufts College Medical School; consultant in gynecology, and director of the Cytology Laboratory, New England Center Hospital. His subject was "Modern Approach to Carcinoma in situ of the Cervix."

On March 9 William Wawro, attending surgeon, Hartford Hospital, spoke to the staff of the Lawrence and Memorial Hospital on "Chemotherapy of Disseminated Cancer."

James M. Sturtevant announces the removal of his office to 358 Montauk Avenue for the practice of pediatrics. Archie Lewandrowski announces the opening of his office at 295 Long Hill Road, Groton for the practice of internal medicine.

The doctors of Groton have recently worked out a plan for emergency coverage on weekends. Norwich already has a plan in operation. This leaves only New London to work out a plan for emergency coverage.

The regular monthly meeting of the staff of the William W. Backus Hospital was held on April 8. Gordon Myers, cardiologist of Massachusetts General Hospital, Boston discussed "The Application of Cardiac Catheterization to the Study of Heart Disease." The meeting was preceded by a dinner.

It has recently been announced that Mrs. Helen Lena, widow of the late Hugh Lena, is giving Dr.

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Waterbury Hospital	- - - -	Waterbury

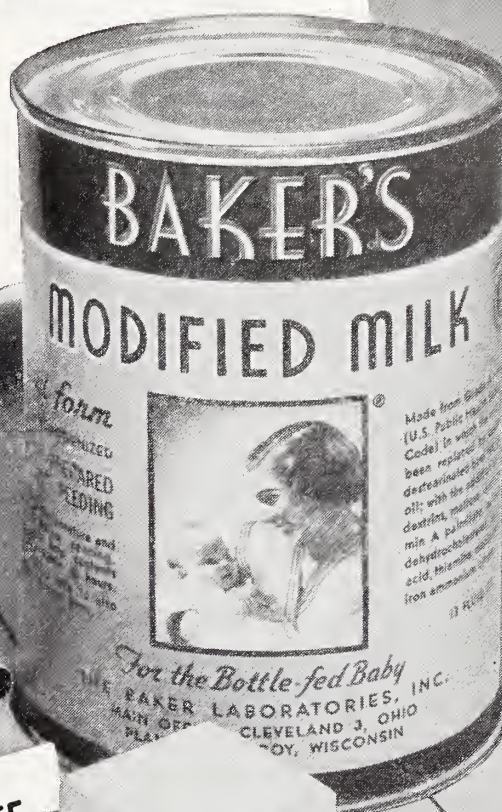
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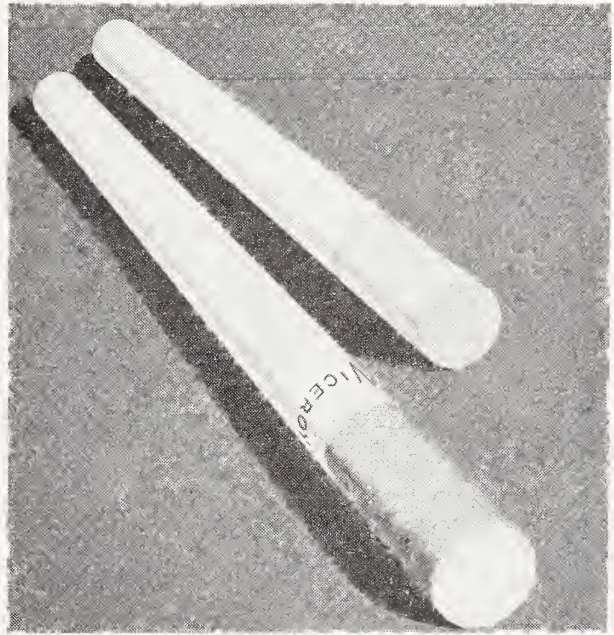
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THE L. E. PHENOMENON AND THE CONCEPT OF THE DISEASE,  
LUPUS ERYTHEMATOSUSWILLIAM M. WIEPERT, M.D., *Avon*

## INTRODUCTION

Over the recent years and concomitant with the development of technical procedures and criteria for more exact diagnosis, systemic lupus erythematosus has assumed an importance disproportionate to its incidence as a clinical entity. That this is so may also be due to an awakened interest, both practical and conjectural, in the whole group of "collagen diseases" in which systemic lupus erythematosus holds a prominent position. Clinically, it has been clearly recognized that the disease has multiple systemic manifestations in addition to its more apparent, but often absent, cutaneous lesions. Finally, a limited but encouraging approach to treatment has become available.

Despite the recent advances, systemic lupus erythematosus remains a febrile disease of unknown etiology, characterized by dermatological lesions, polyserositis, depression of the bone marrow elements, and widespread visceral involvement. It occurs in both sexes, young and old, but has a predilection for fair-skinned individuals and females of childbearing age. The known duration of the disease rarely exceeds five years. In 60 per cent of autopsy cases wire looping of the renal glomerulus is found. Verrucous endocarditis occurs in 40 per cent. Less distinctive, but of common occurrence, are periarterial fibrosis of the spleen and generalized vascular lesions. There is a trend among dermatologists, pathologists and internists to recognize an acute, subacute and chronic stage of the disease. As these stages are difficult to differentiate except after prolonged observation, Haserik<sup>3</sup> has suggested the name, systemic lupus erythematosus, to cover the generalized form of the disease. He uses "discoid" and "dissemi-

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The Author. *Assistant in Department of Medicine,  
Hartford Hospital, Hartford, Connecticut*

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## SUMMARY

The L. E. phenomenon has been described in its identity, composition, mechanism and specificity.

The discovery of the L. E. cell has added a simple and practical procedure to the diagnosis of systemic lupus erythematosus.

An endocrine factor, a hypersensitivity state, and third, an abnormal enzyme activity upon connective tissue have been discussed as being of etiologic significance in this disease. Aggravation of the clinical manifestations of systemic lupus erythematosus may occur with the administration of drugs, ultraviolet light, trauma and operative procedures.

---

nate" to describe the location and extent of skin lesions when present.

In this paper little emphasis is placed upon the clinical and pathological manifestations of systemic lupus erythematosus per se. Following a brief historical background leading to the discovery of the L. E. cell, the component parts of the L. E. phenomenon, its mechanism and specificity are discussed. Finally, the current thoughts as to its etiology are presented.

## HISTORICAL BACKGROUND

In 1828 "erytheme centrifuge" was the first descriptive term used for systemic lupus erythematosus. Priority for this is given to Theodor Bielt in a review by Cazenave and Chausit in 1853. Hebra<sup>13</sup> called it "seborrhoea congestive" in 1845. In 1851



Cazenave, remarking upon the intense alteration and scarring of the skin, classed it with lupus vulgaris. He gave it the name of "lupus erythematosus" to distinguish it from the latter. Hebra in 1856<sup>13</sup> attributed two forms of skin lesion to this same disease; (1) a disc-like or discoid form, and (2) a form which he called "lupus erythematosus disseminatus" or "aggregatus."

Kaposi<sup>8</sup> studied the pathological anatomy and in 1872, without differentiating the chronic and acute forms, described systemic lupus erythematosus as a generalized and disseminated, acute and subacute, febrile eruption with grave local and constitutional symptoms, sometimes endangering the life of the patient. The cause of death in his cases was either pneumonia or tuberculosis.

An associated sensitivity to cold known as "chill-blain" lupus was recorded by Hutchison in 1884.<sup>13</sup> It is thought by Ross and Wells<sup>13</sup> that this might have been a manifestation of the Reynaud's phenomenon which is seen in systemic lupus erythematosus and in other "collagen diseases."

In discussing the fifty year period beginning in 1880, Klemperer<sup>8</sup> states that "it is amazing that the postmortem studies during this period disclose nothing unusual, and it is more amazing that clinicians and pathologists for so many years seem to have been satisfied that so striking a clinical picture should not be associated with some more unusual pathologic alterations at necropsy than tuberculosis and pneumonia."

At the turn of the century Jadasshon<sup>8</sup> summarized contemporary dermatologic experience in the recognition of acute systemic lupus erythematosus as a constitutional disease. He laid great stress upon the joint symptoms, ulcerations of mucous membranes, glandular swellings and renal involvement. These findings he attributed to infection or toxins. Osler remarked on the systemic manifestations of "lupus exudativum" in 1904 with a summary of 29 cases. According to Tumulty<sup>14</sup> he also mentioned the endocardial lesions and the fact that the disease might occur in the absence of skin lesions.

These previous observations received little attention until Libman and Sacks<sup>8</sup> in 1923 described four cases of an atypical and nonbacterial verrucous form of endocarditis in two of which there were the cutaneous lesions of acute lupus erythematosus. They considered the skin lesions important only to call

attention to the possible coexistence of endocarditis. In the light of the present knowledge of systemic lupus erythematosus, their pathological findings are significant. They described the "pericarditis, white-centered petechii, arthritis, erythematous and purpuric rashes, ulcerative lesions of mucous membranes, pleuropulmonary lesions (three pleural effusions) and embolic phenomena enlargement of the liver, acute glomerular nephritis, a tendency to leucopenia and repeatedly negative blood cultures."

Klemperer, Pollack and Baehr in 1941 and 1942<sup>8,9</sup> brought forth the fact that the apparently heterogeneous changes in serous membranes, heart, blood vessels, kidneys, spleen, skin and other tissues were manifestations of an identical morbid process, the fundamental nature of which was an alteration of the connective tissue. Elements of this tissue—fibroblasts, fibers and ground substance—showed morphologic evidence of injury manifested by swelling of the ground substance, a straight rigid and irregularly thickened appearance of the fibers, proliferation and degeneration, and in some instances necrosis of the fibroblasts. The changes so described had already been designated "fibrinoid degeneration" by Neumann in 1880. Klemperer pointed out that fibrinoid degeneration was common to such systemic processes as rheumatic fever, scleroderma, periarteritis nodosa, glomerulonephritis and systemic lupus erythematosus. He grouped these entities under the term of collagen disease. In systemic lupus erythematosus, the profound cytochemical disturbance showed a dominance of the degenerative over the proliferative phase of collagen alteration. The authors remarked upon the nonspecificity of fibrinoid degeneration. It has been described as occurring locally at the base of peptic ulcers, sites of bacterial infection, around foreign body implantations and at the sites of other palpable injury. It had also been described in lesions associated with the hypersensitive state. In the absence of demonstrable cause, it was suggested that systemic collagen alteration might be an expression of a hypersensitivity state. However, the classic clinical evidence of hypersensitivity so frequently observed in periarteritis nodosa was lacking in systemic lupus erythematosus.

Rich<sup>13</sup> in 1946, presenting data on periarteritis nodosa and experimentally produced serum sickness, noted in agreement with other workers the clinical and pathological overlapping and transitions between experimental serum sickness, human serum sickness,

periarteritis nodosa, rheumatic fever, lupus erythematosus, sulfonamide hypersensitivity and rheumatoid arthritis. He presented some evidence that anaphylactic hypersensitivity was an underlying factor in the connective tissue alterations of this group.

The most important advance in the diagnosis of systemic lupus erythematosus occurred with the demonstration of the L. E. cell in 1948 by Hargraves, Richmond and Morton.<sup>2</sup>

#### THE L. E. PHENOMENON

For the production of the L. E. phenomenon three elements are essential: (1) active polymorphonuclear leucocytes; (2) a nucleoprotein material; and (3) the plasma or serum L. E. factor. The phenomenon itself consists of the visible presence of L. E. cells and rosettes, the latter being defined as clumps of phagocytosing polymorphonuclear cells surrounding masses of homogeneous basophilic material.

#### A. THE L. E. CELL

Hargraves, Richmond and Morton<sup>2</sup> at the Mayo Clinic were working with heparinized bone marrow preparations when they first reported the L. E. cell in 1948. Over a two year period they noticed a cell which appeared only in cases of systemic lupus erythematosus. This cell, which they designated the L. E. cell, was almost always a mature polymorphonuclear leucocyte seen best in clumps on the fringe of slide preparations. It was active in phagocytosis of free nuclear material. It showed a round vacuole of varying size in its cytoplasm containing partly digested and lysed nuclear material. At times one or more of the lobes of the polymorphonuclear cells appeared to swell, degenerate and become pale. They then became either L. E. cells in situ or the lobular masses were extruded and phagocytized by others. The presence of this cell was suggested as a possible diagnostic aid in systemic lupus erythematosus.

The same authors described a second cell whose occurrence was associated with chronic infection and debilitating disease. They named this cell the "Tart" cell after the name of the patient in whom it was first noted. It had been observed as an histiocyte, a polymorphonuclear or eosinophilic leucocyte. There was a secondary more darkly staining nuclear mass in the Hof of the primary nucleus. In contrast to the lysed cytoplasmic inclusion of the L. E. cell this secondary nuclear mass had a sharply defined nuclear membrane and its chromatin and parachro-

matin components were readily differentiated. In the same year, Haserick and Sundberg<sup>5</sup> described the L. E. cell in 4 out of 5 cases of systemic lupus erythematosus. Other workers using oxylated peripheral blood found L. E. cells but in numbers so small that they doubted the practicality of this method as a test.

L. E. cells have been found in body fluids other than the blood: namely, the spinal fluid, pleural fluid and the pericardial fluid. In one instance the plasma of the patient with lupus erythematosus was applied to the exposed papillary layer of the forearm in two volunteers whose skin had previously been treated with diphtheria toxoid to produce inflammation. One hour after the application the L. E. cell was demonstrated in smears taken from the "window" site. In another instance vesicles were produced on the skin of a patient with systemic lupus erythematosus with the use of cantharides paste. Smears from the fluid and base of the blisters showed the L. E. cell.

In 1949 Haserick and Bortz<sup>4</sup> added patient's serum to normal heparinized bone marrow and brought about the formation of single L. E. cells and groups of polymorphonuclear cells arranged in rosettes as they phagocytized clumps of basophilic material. This they called the L. E. phenomenon. They postulated an L. E. factor in the serum responsible for the phenomenon.

Haserick<sup>3</sup> produced the phenomenon using patient's serum and the buffy coat of dog bone marrow. Others obtained the L. E. phenomenon with patient's serum and the white blood cells of laboratory animals such as the opossum, rat, rabbit and guinea pig.

There is general accord that the use of peripheral blood for diagnosis is satisfactory. The simplest and most effective method for producing a positive test is the MaGath modification of the two hour blood clot used at the Mayo Clinic.<sup>11</sup> Five cc. of venous blood is allowed to clot in a clean test tube at room temperature for 1½ to 2 hours. The clot is removed and pushed through a No. 40 mesh stainless steel wire screen (such a screen can be made to fit over an open petri dish). The fractionated clot is then centrifuged and the buffy coat smeared and stained with Wright's stain. Another technique used on the bone marrow consists of mixing equal parts of bone marrow aspirate and a solution of heparin. This mixture is incubated 30 min. at 37° C and centri-



fused. The buffy coat is smeared and stained in a similar manner. It has been noted that "Tart" cells are seen frequently with the peripheral blood technique but, if the previously mentioned criteria are followed, there should be no confusion with the L. E. cell.

#### B. THE L. E. INCLUSION BODY

Histochemical studies of the structureless basophilic mass of the L. E. inclusion body indicate that it is desoxyribosenucleic acid (DNA) which is in part or poorly depolymerized. Klemperer, Gueft and Lee et al.<sup>7</sup> in 1950 found that the free masses of hematoxylin-staining material seen at autopsy only in systemic lupus erythematosus exhibit the same spectrophotometric and staining reactions characteristic of poorly polymerized DNA. They trace the origin of these masses to fibroblasts, histiocytes, endothelial cells (Kupfer cells included), lymphocytes and polymorphonuclear leucocytes, all of mesenchymal origin. There was a striking similarity between changes in the tissues and those in the bone marrow and blood of patients with systemic lupus erythematosus. They suggested that the degrading process of the DNA was effected through the action of an enzyme system.

Kurnick et al.<sup>10</sup> were unable to show that the enzyme DNase when found free in blood serum or when added to the serum could produce the L. E. phenomenon. However, when they investigated the intracellular DNase, they demonstrated in human leucocytes the presence of an inhibitor for both human DNase and the L. E. phenomenon. The inhibitor was a protein and soluble in saline. It was destroyed by heat at 100° C; it was stable at 50° C and on storage for several months at -20° C. They hypothesized that the L. E. factor, which had no DNase activity itself, caused a release of intracellular DNase from inhibition with resultant depolymerization of DNA. They found a greater amount of inhibitor in the cytoplasmic fractions of lymphocytes and immature polymorphonuclear cells, a fact in keeping with observations that the mature polymorphonuclear cell was the most frequent source of DNA.

#### C. THE SERUM FACTOR

Several properties of the L. E. factor have been elucidated.<sup>13</sup> With the use of protein fractionation techniques the factor responsible for the production of the L. E. phenomenon was found in the gamma globulin portion of the serum protein. The factor

was not found in other disease states associated with hyperglobulinemia. The phenomenon could be evoked by using the gamma globulin fraction alone with normal white cells in the absence of serum complement. It was stable between 0 degrees centigrade and 65 degrees centigrade and could be stored for six months if kept sterile. The phenomenon was inhibited by para-aminobenzoic acid but not by cortisone, testosterone, estradiol or progesterone. Antibodies developed in rabbits against gamma globulin containing L. E. factor inhibited the phenomenon when they were added to test mixtures. Conversely, antibodies against normal gamma globulin or the gamma globulin of patients with chronic lupus erythematosus did not inhibit the phenomenon.

In 1952 Hargraves<sup>1</sup> suggested that since the L. E. test was essentially an in-vitro phenomenon, the most logical change that might cause potentiation of the L. E. phenomenon occurred in the coagulation of blood. He thought platelets or their disintegrating products might be a source of the L. E. factor.

It has been postulated that a pathologic serum gamma globulin is produced in collagen disease and that in systemic lupus erythematosus it is associated with the plasma factor. Attention has been directed to the elevated levels of mucopolysaccharides and nonspecific hyaluronidase inhibitors in patient's serum.

While studying a "heparinoid" material as an anticoagulant for blood, Interbitzin<sup>6</sup> noted the formation of L. E. cells following incubation of this material with normal serum and buffy coat cells. He pointed out that heparinoid material and mucopolysaccharides were related physicochemically and biologically. He suggested the combination of a pathologic mucopolysaccharide with gamma globulin to form the L. E. factor.

Moolton and Clark<sup>12</sup> presented another view. They identified a virus in six cases of systemic lupus erythematosus and proved the relationship of the strains by agglutination procedures. The viruses were capable of producing the L. E. phenomenon in vitro after 11 passages through the chick embryo. This phenomenon could be blocked by specific immune serum which also agglutinated in fairly high titre the red blood cells of patients suspected of lupus erythematosus. In one instance the husband of a patient with systemic lupus erythematosus when injected repeatedly with the patient's formalin-inactivated virus developed a rising titre of anti-

body. His serum inhibited the L. E. phenomenon when mixed with the patient's serum or virus. Transfusion of his plasma into the patient appeared to induce temporary, partial clinical remission.

#### D. THE L. E. PHENOMENON

It has been shown that the process by which the L. E. phenomenon takes place is first, the depolymerization of DNA; secondly, a chemotactic attraction of the polymorphonuclear cells with thirdly, phagocytosis of the DNA by the polymorphonuclear cells.

In over 3,000 L. E. tests reported in the literature false positive tests for the phenomenon have occurred rarely. Ross and Wells<sup>13</sup> state that the test may be considered specific.

Single instances of positive L. E. tests have been reported in pernicious anemia, dermatitis herpetiformis, leukemia, multiple myeloma and miliary tuberculosis. A plasma sample contaminated with *aspergillus* simulated the L. E. phenomenon. The L. E. cell was reported in a patient with moniliasis. A pseudo-L. E. cell has been described in amyloidosis.<sup>13</sup>

Walsh and Zimmerman<sup>15</sup> reported six cases of patients with penicillin reactions simulating serum sickness. In three of these patients with severe reactions both L. E. plasma factor and L. E. cells were demonstrated. The cells disappeared with the disappearance of the reaction. The authors were not sure of the interpretation of this finding. They realized that coexistent systemic lupus erythematosus could not be ruled out, but suggested also (1) nonspecificity of the test, (2) pathologic and serologic reactions similar to systemic lupus erythematosus caused by penicillin, and (3) hypersensitivity without the histologic changes of systemic lupus erythematosus.

#### DISCUSSION

The discovery of the L. E. cell has led to the development of a simple practical clinical method for determining the presence of systemic lupus erythematosus. Consequently, the incidence of reported cases has arisen. Factors previously thought to have etiologic significance are now considered sensitizing agents or aggravators of the clinical symptoms.

There are several schools of thought as to the etiology. An endocrine factor has been proposed by one group; a hypersensitivity factor by another; a

third group has held that the altered connective tissue is a manifestation of an enzyme action.

In spite of the predilection of the disease for females during active menstrual life, it has not been shown that hormonal secretion plays a role in the etiology of systemic lupus erythematosus. Premenstrual exacerbations treated with testosterone were considered benefited in some cases but the overall results were not significant.<sup>13</sup> Likewise, castration had no effect. Pregnancy caused no significant alteration in the clinical course of the disease.

Proponents of the theory of hypersensitivity have postulated an abnormal antigen-antibody reaction in the tissues. Infectious organisms, viruses and foreign proteins have been incriminated as antigens. Several frequently observed clinical and laboratory features of the disease have been emphasized as evidence of this theory. Abnormal immunological backgrounds have been present in patients with systemic lupus erythematosus: namely, a tendency toward transfusion reactions, biological false positive tests for syphilis and a high serum globulin of the gamma globulin type. Aggravation of the clinical manifestations by drugs (in particular gold, sulfonamides and penicillin) by ultraviolet light, trauma and operative procedures has occurred. Monovalent or incomplete antibodies have been demonstrated in a fair percentage of cases tested by the Coombs antiglobulin test. Although hemolytic anemia, thrombocytopenic and thrombotic thrombocytopenic purpura have been considered by some workers as individual diseases coexistent with systemic lupus erythematosus, others have pointed to them as further evidence of an abnormal antigen-antibody state. A final bit of corroboration for the hypersensitivity theory has been claimed as a result of the apparently beneficial response of systemic lupus erythematosus to ACTH and cortisone therapy.

However, there is a group that does not think the evidence for the hyperallergic theory is valid. They point to the nonspecificity of fibrinoid degeneration emphasizing that it may be seen in a variety of conditions some of which may not be correlated with the hypersensitivity state. The very existence of the L. E. factor in the serum of patients with systemic lupus erythematosus and the demonstration that the factor does not bring about the depolymerization of DNA has led this group to express the belief that another mechanism is responsible for the etiology of the disease. The demonstration of increased blood levels of enzymes such as hexosamines or mucopoly-



saccharides has suggested that the process is effected through abnormal enzyme activity. Furthermore, it has been demonstrated that the L. E. factor blocks the normal inhibition of depolymerizing enzymes.

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## A STUDY OF OVARIAN CARCINOMA

MUCH can be done to improve the treatment of ovarian carcinoma by more widespread application of the available knowledge in this inaccessible disease. The five year salvage at present averages about 20 per cent.

Many reports have emphasized the silent onset in these cases, the majority of which finally present themselves because of abdominal pain or enlargement while a smaller number note abnormal vaginal bleeding. About two-thirds of the cases appear to have widespread involvement at the time that they seek medical attention. There are, however, several facts known about this disease which present a more hopeful constructive approach.

Some 10-20 per cent of female genital cancers are ovarian and about two-thirds of these are carcinomatous changes superimposed upon papillary serous cystadenomas. Many of these still benign cystic tumors could be picked up on routine six months pelvic examinations if performed on all females over the age of 35 years.

The use of postoperative x-ray therapy has been shown to improve the five year salvage and prolong life in those cases which do not survive five years.<sup>1,2,3,4,5</sup>

Pathologically it is known that there are various types of carcinoma of the ovary which differ widely

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#### SUMMARY

In reviewing the Meriden Hospital tumor clinic records on carcinoma of the ovary for the period 1935-1951 many encouraging aspects were discovered. In spite of the inaccessibility of this tumor, the more universal application of complete and adequate surgery coupled with x-ray therapy appeared likely to raise the salvage beyond the present average rate of 20 per cent. Semi annual pelvic examinations in all females beyond the age of 35 years would lead to early discovery and the removal of the still benign ovarian tumors which are known to precede two-thirds of all ovarian cancer.

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in their five year salvage rates. Papillary serous cystadenocarcinoma, (borderline and Grade I), pseudomucinous cystadenocarcinoma and granulosa cell carcinoma offer the best prognosis.<sup>4</sup> These investigators also found that in the serous cystadenocarcinoma which makes up about two-thirds of all ovarian carcinoma grading is important: Grade I 89.8 per cent, Grade II 48.2 per cent, Grade III 21

per cent, and Grade IV 6.1 per cent five year salvage. Heckel found that in general the prognosis was determined by the degree of removability of the growth plus the use of radiation; this combination he believed largely determined the survival time.

From the surgical standpoint, since there is early spread of ovarian carcinoma to the other ovary and the uterus, removal must be complete, that is, either panhysterectomy or subtotal hysterectomy plus bilateral salpingo-oophorectomy. There is relatively little statistical difference in salvage between panhysterectomy and subtotal hysterectomy, although the trend in general is toward panhysterectomy.

While the above points deal with treatment and prognosis, much can be accomplished in prophylaxis. Crossen<sup>6,7</sup> has long advocated removal of involuting ovaries at gynecological operations, six monthly examination of females over the age of 35 and the early removal of ovarian cysts, especially in the menopausal patient where any ovarian enlargement should be suspect of being early ovarian carcinoma.

With these facts in mind it is instructive to review the statistics on ovarian carcinoma as recorded in the tumor records of the Meriden Hospital Tumor Clinic. Fifty-eight cases of ovarian carcinoma were recorded in the Meriden Hospital Tumor Clinic records between 1935 and 1951 inclusive. Forty-eight cases were seen prior to 1948 with a five year salvage of 18.8 per cent.

1935	48 cases	Living in years	6	} 5 cases	
			13		
			15		
			9		
			10		
		Dead but lived in years	16	} 4 cases	
			6		
			9		
			8		
		Dead and lived less than 5 years—			
1947		39 cases			
1948	10 cases	Living in years	2	} 7 cases	
			5		
			1		
			2		
			2		
			1		
			1		
		Dead and lived less than 5 years—			
		3 cases			
1951					
Total 58 cases					

The type of operation performed is presented below:

Exploratory lap.-biopsy .....	16
Subtotal or panhysterectomy with bilat. salpingo-oophorectomy .....	14
Bilat. salpingo-oophorectomy .....	8
Unilat. salpingo-oophorectomy .....	16
None (pathology found at postmortem) .....	4
Cesarean and appendectomy .....	1

The percentage of complete operation was 25.8 per cent. Of those living 58.3 per cent had a complete operation while only 17.4 per cent of those now dead with less than a five year survival had a complete operation.

Very few cases had x-ray in addition to operation. Among those cases seen prior to 1948 there were four treated by x-ray. These survived 8, 4, 3 and 1 year and made up 8.3 per cent of the cases; while in those cases since 1948, 30 per cent received x-ray therapy. It was also a sign of progress to note that prior to 1948, 18.8 per cent were treated by complete operation whereas since then 50 per cent were treated by complete operation.

It is instructive to consider the type of situation leading to survival. The patient had a type of tumor with a normally good prognosis (pseudomucinous cystadenocarcinoma, Grade 1 or 2, papillary serous cystadenocarcinoma or granulosa cell carcinoma), had the benefit of either complete operation or x-ray or both, or in several cases in addition was benefited by fortuitous circumstances leading to unusually early diagnosis. In one case an ovarian cancer was discovered at a gall bladder operation, while a Meigs' syndrome in another case led to early diagnosis. In another case an early diagnosis was made possible because of a routine six months check-up.

The symptoms which brought the patient to the physician were:

Abdominal pain .....	22	} 69%
Abdominal enlargement .....	11	
Mass in abdomen .....	7	
Vaginal bleeding .....	6	
None .....	5	
Fatigue, etc. ....	4	
Meigs' syndrome .....	3	

Thus abdominal pain and enlargement either generally or locally were present in 69 per cent of the cases while vaginal bleeding was the presenting symptom in 10 per cent. In 36 per cent of the cases the symptoms were present for six months or longer and in the past five years there appears to be no improvement in this delay factor.



By age, the cases were distributed as follows:

3rd	4th	5th	6th	7th	8th	Decade
4	13	18	13	8	1	

#### DISCUSSION

The application of our present knowledge can raise the five year salvage in ovarian carcinoma appreciably. The beneficial effect of x-ray in these cases is generally accepted and recommended. By the use of postoperative x-ray in all cases where the spread is beyond the ovary the five year salvage was raised by Kerr and Elkins<sup>5</sup> to 31.5 per cent. Meigs<sup>8</sup> in a report stressed the fact that two-thirds of those surviving five years or more in his series had the benefit of x-ray and his five year salvage rate was 28.4 per cent.

Even in seemingly hopeless cases in which only a biopsy is feasible at exploratory operation, Parks<sup>9</sup> has reported three cases which were treated with deep x-ray therapy and later more definitive surgery so that they survived 8, 12 and 5 years, respectively. In hopeless appearing cases such a regime of therapy is to be recommended. In our series those receiving x-ray fared better than those treated by surgery alone and it was encouraging to find that in the past five years 30 per cent received the benefit of x-ray therapy in addition to surgery compared to 8.3 per cent previously.

Surgically the value of complete operation cannot be over stressed. It was not entirely technical difficulties or inoperability which limited the surgery to one or both adnexae in 43 per cent of the cases, but frequently lack of knowledge that complete operation was indicated or ignorance of the pathology with which the operator was dealing which led to incomplete operation. It is encouraging to note that in the past five years 50 per cent of the cases received the benefit of complete operation compared to 18.8 per cent previously.

The presence of an ovarian tumor would seem an indication for operation in general but when one is acquainted with the fact that two-thirds of ovarian cancer are preceded by ovarian tumors which at one time are not yet malignant, then the removal of any ovarian tumor becomes a must if we are to increase the five year salvage rate in this disease. One finds it

difficult to conceive of a patient who would wish to retain such a tumor when acquainted with the facts. Yet in our series there were several patients with a known ovarian mass of from one to several years duration before malignancy apparently set in, and in some of the cases this knowledge was known to both the physician and the patient.

The six monthly periodic pelvic examination in all females over the age of 35 years must at present remain our basic prophylactic measure against carcinoma of the ovary until the time comes when some nonspecific screening test for cancer becomes available. The prophylactic removal of involuting ovaries long stressed by Crossen<sup>6,7</sup> is to be recommended in all patients subjected to pelvic surgery for other reasons. A point brought out in the Meriden Hospital Tumor Clinic statistics is that advantage should be taken of every possible opportunity to observe and palpate the ovaries during any abdominal operation on a female, especially beyond the age of 35 years. Several patients in our series owe their five years survival to such a practice on the part of their surgeon.

The prophylactic aspects of this problem deserve more publicity in cancer prevention programs.

#### CONCLUSIONS

The five year salvage statistics in ovarian cancer can be made to compare more favorably with those in other types of cancer if our present day knowledge is more generally applied.

More stress should be given to the prophylactic and preventive approach to cancer of the ovary.

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## ELECTROCARDIOGRAPHIC CHANGES SIMULATING RECENT MYOCARDIAL INFARCTION

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### SUMMARY

Two cases have been presented that entered the Manchester Memorial Hospital with what was apparently acute upper abdominal disease. In both cases there were electrocardiographic findings simulating recent myocardial infarction. Mr. T. M., a white male, age 65, developed severe upper abdominal pain while in church. His serum amylase was over 1100 units and he had boardlike rigidity in his upper abdomen. The serial electrocardiograms revealed abnormal Q waves, S T elevations and depressions with T wave inversions consistent with a diagnosis of recent myocardial infarction. Autopsy showed that the Q waves were due to an old myocardial infarction and the S T and T wave changes were due to a circumscribed area of acute fibrinous pericarditis. Death was due to acute hemorrhagic pancreatitis.

Mr. H. P., a white male, age 80, was at first thought to have had acute appendicitis. His appendix was removed. Some days later he developed right upper quadrant pain that suggested acute cholecystitis. He was later operated on for this and gall stones were found. During his acute upper abdominal distress he developed electrocardiographic changes consistent with a diagnosis of recent myocardial infarction. He later expired due to a bleeding duodenal ulcer. Autopsy revealed no abnormal cardiac findings. These two cases demonstrate that in acute upper abdominal diseases the electrocardiogram may show changes which simulate recent myocardial infarction.

had occurred since the electrocardiographic tracing had returned to normal in such a short period of time and it was concluded that the electrocardiographic changes were due to the allergic phenomena.

Wallace, Katz, Langendorf and Buxbaum<sup>2</sup> state that in toxemias of pregnancy electrocardiographic changes do occur. They stated that patterns sug-

MYOCARDIAL infarction has become a fairly common disease. The diagnosis of recent myocardial infarction is not difficult when the symptoms are typical, that is, when there is substernal pain which radiates down the left shoulder, the left arm, lasts for hours, and is relieved by morphine. When the symptoms are not classical but are accompanied by typical electrocardiographic findings such as, deep Q waves, S T elevations and reciprocal S T depressions plus T wave inversions, one can still with little hesitancy say that this is a case of recent myocardial infarction. In those cases in which the symptoms present are suggestive of a recent myocardial infarction and the electrocardiographic findings are equivocal, a diagnosis of recent myocardial infarction is difficult. Most puzzling are those occasional cases in which the symptoms appear to be those of recent myocardial infarction and the electrocardiographic findings are indicative of such disease but which at autopsy reveal patent coronary vessels and no evidence of recent myocardial infarction. Because of recent experience with two cases such as those last mentioned, we looked through the literature and found that others have had experiences somewhat similar in nature.

Foster and Layman<sup>1</sup> state that the literature reveals that there are acute cardiac manifestations associated with urticaria and that definite cardiac changes may accompany allergic reactions. They report a case of a white woman age 65 who developed urticaria following medications, and whose electrocardiographic changes simulated myocardial infarction. The cardiogram in this case was interpreted as a recent posterior myocardial infarction. There was complete A V dissociation and I V block. Twelve days after the original electrocardiogram when the patient had improved, another electrocardiogram was taken which was normal except for first degree heart block. It was felt in this case that no myocardial infarction



gestive of an acute myocardial infarction were found in two cases in which there was toxemia of pregnancy. These men point out that pathological observations in hearts that showed electrocardiographic changes always revealed focal myocardial necrosis, edema or infiltration. They feel that these electrocardiographic changes were produced by the focal myocardial necrosis, infiltration and edema rather than by myocardial infarction secondary to occlusion of a coronary artery. They state that it is known that left axis shift, a prominent Q and a deep inversion of the T wave in lead 3 develop in normal pregnancy. They also state that inversion of the T waves in leads C F 2 and C F 4 may occur in the last trimester of pregnancy but that these revert to normal within a week after delivery.

Hodge, Messer and Hill<sup>3</sup> made an experimental study of the effect of distension of the biliary tract on the electrocardiogram. They state that many times it is difficult to differentiate between gall bladder colic, angina pectoris or coronary occlusion and that the electrocardiogram is not always an aid to the correct diagnosis since in the literature such diseases as cholecystitis, pancreatitis and perforated peptic ulcer may cause electrocardiographic alterations. These alterations may be T wave changes, S T elevations and depressions and notching of the Q R S complexes. They carried out a series of experimental studies to find out whether a normal heart may develop cardiac changes due to gall bladder abnormality. They found that in the group of animals in which there was no cardiac pathology, gall bladder abnormality did not significantly alter the electrocardiogram, but in those animals in which cardiac damage was present and the gall bladder pathology was superimposed, electrocardiographic changes became apparent. They distended the animal's gall bladder acutely in order to bring about gall bladder abnormality and watch its effect on the electrocardiogram. They concluded that distension of the biliary tract in dogs without a pre-existing lesion of the coronary artery or the myocardium failed to produce any significant changes in the electrocardiogram, while the same after ligation of one or more coronary arteries produced abnormal deviations of the R S T segments of the electrocardiogram.

Laird<sup>4</sup> reviewed a series of 65 cases of disease of the gall bladder and biliary tract. There were 58 females and 7 males. Fifty of these patients had a clinical cardiac lesion while the remaining 15 revealed no clinical evidence of a departure from

normal in the state of the cardiovascular system. It was possible to compare in 40 cases of this series the preoperative, postoperative and follow-up electrocardiograms. This comparison revealed that the electrocardiogram was not in all cases an accurate indication of the state of the myocardium and on occasion there was difficulty in correlating it with any change which the clinical cardiac manifestations might display. In cases in which coronary artery thrombosis had occurred, however, the electrocardiographic findings confirmed the clinical diagnosis and proved of definite value in the prognosis. He also states that the clinical manifestations of gall bladder disease may closely simulate disease of the heart, particularly coronary artery disease, and that the reverse is equally true.

Fitz-Hugh and Wolferth<sup>5</sup> present data obtained in a small group of patients with cardiac complaints before and after surgical removal of gall stones. As far as the writers could ascertain no similar study had been recorded at that time. These patients all exhibited cardiac symptoms, chiefly anginal in character but for the most part not of the effort type, and all were found to have abnormal electrocardiographic tracings, chiefly flat or inverted T waves in the first two leads. Two of these patients had no previous manifestations of gall bladder disease despite the presence of gall stones in all.

#### CASE 1

Mrs. K, age 60, had severe precordial pain radiating to the left shoulder, usually nocturnal, rarely induced by exertion and present since 1925 off and on. She was seen in 1930. In addition she had attacks of pain in the abdomen suggesting gall stones. X-rays showed non visualized gall bladder. Electrocardiogram showed frequent premature ventricular beats and T wave inversions in all leads. The inverted T waves were regarded as evidence of severe myocardial disease with serious outlook. It was concluded that coronary artery disease was present. She got worse as time went on. Finally she became jaundiced and operation became imperative. The gall bladder was removed and stones were present. Convalescence was uneventful. Anginal and dyspeptic symptoms disappeared. Six weeks after operation an electrocardiogram showed upright T waves in leads 1 and 2 where previously inverted. Now at age 64 she plays golf and leads a normal life.

Five other cases were presented in this series all having abnormal electrocardiographic tracings and gall bladder disease, all having symptoms suggestive of coronary artery disease and all of whom following operation improved both clinically and in their electrocardiographic findings.

Fitz-Hugh and Wolferth concluded that electro-

cardiographic changes, mainly flat or inverted T waves in leads 1 and 2, occurred in the presence of gall bladder disease and disappeared after surgical intervention. They felt that the disease in the gall bladder in some unexplained way affected the heart.

Clarke<sup>6</sup> writes about electrocardiographic changes in active duodenal and gall bladder disease. He states that a growing literature attests the relationship of both upper right abdominal disease and attacks of acute substernal pain which simulate angina pectoris or even coronary occlusion. An accurate differential diagnosis is essential especially when surgical risk is involved. The pain of coronary occlusion is sometimes referred to the abdomen and resembles that of acute upper abdominal disease. In such instances we rely heavily on the electrocardiogram in the differential diagnosis. Our aging population has produced a higher incidence of associated gall bladder and coronary artery disease and rarely acute conditions of both diseases occur simultaneously. It is important that electrocardiographic changes which are found in the presence of these diseases should not be misinterpreted. He presents cases which show an unusual alteration in the electrocardiogram which may be important in the differential diagnosis of acute duodenal and gall bladder disease and coronary occlusion.

One case, that of a man age 44 with abdominal distress and upper abdominal and lower chest pressure was presented. While this man was removing his car from the garage after breakfast he was seized with severe burning pain beneath the sternum which did not radiate. The pain was made worse on movement and lasted five minutes. He had subsequent repeated attacks of substernal distress on exertion which were relieved by rest. X-ray revealed a duodenal ulcer. There were T wave changes in lead C R 4 which gradually disappeared with rest and diet. Another case was presented in which x-ray showed a diverticulum of the duodenum with signs of irritability. The electrocardiogram showed changes in T<sub>1</sub> and T<sub>4</sub> which reverted to normal with diet and rest. Later this patient was entirely symptom free and carrying on regular work.

A third case was presented, that of a physician, age 57, with typical attacks of coronary insufficiency which were present over a period of 12 years. Certain foods and exertion would precipitate the attack and rest and sedation would stop it. The patient had been told that he had both cholecystitis and coronary occlusion. In August 1941 while walking he had

severe substernal pain, bloating and gas. Standing still gave relief. He managed to get home but was perspiring profusely and vomited. He was in mild shock. Morphine was required. The next day he felt perfectly well. Several weeks after this attack x-rays showed chronic cholecystitis. Serial electrocardiograms showed S T and T wave changes which later reverted to normal. Clarke concludes that acute inflammatory and ulcerative conditions involving the gall bladder or duodenum cause irritation and spasticity of the surrounding structures and create stimuli which act reflexly through autonomic pathways to restrict or in some other manner alter the coronary blood supply. It seems probable that due to these minor alterations in the coronary circulation the electrocardiographic changes are brought about.

Murphy and Liveseg<sup>7</sup> state that the differential diagnosis between myocardial infarction and acute surgical lesions of the upper abdomen is at times difficult, yet obviously of the greatest importance. They discuss the case of a white man age 68 who was hospitalized on February 8. On the day of admission the patient became weak and collapsed on the street. The past history revealed upper abdominal pain for ten years. The pain was dull and non radiating. The patient lost weight and resorted to bicarbonate. The blood pressure at this time was 170/100. The patient continued to have dull pain following meals. There was melena and hematemesis. On February 10 there was sudden severe epigastric pain with a typical boardlike belly. The blood pressure fell to 60/30 and shock was present. An electrocardiogram revealed S T depressions in leads 1, 2 and C R 4 and 5, which strongly suggested lateral wall infarction of the left ventricle. However, a diagnosis of perforated ulcer was made. The patient died seven hours after onset. Autopsy revealed no old or recent coronary occlusion or myocardial infarction.

Gottesman, Casten and Beller<sup>8</sup> discuss changes in the electrocardiogram induced by acute pancreatitis. They tell of a man, age 38, admitted to the hospital on May 30, 1938. He had chills, fever and upper abdominal pain. The pain became progressively worse. An electrocardiogram taken before entering the hospital showed changes which were interpreted as indicative of an acute coronary occlusion. An electrocardiogram at the hospital on May 30 showed notching of P<sub>2</sub> and P<sub>3</sub> and premature auricular beats. The patient died. No autopsy was obtained. They tell of a man, age 53, who four hours after onset of abdominal pain and gaseous eructation



vomited and had severe substernal oppression. He had had similar previous severe episodes. At this time an electrocardiogram was taken which showed auricular fibrillation and was interpreted as indicative of posterior myocardial infarction. Further clinical course suggested coronary thrombosis. Autopsy showed pancreatitis and no coronary occlusion or myocardial infarction.

Another case that of a male negro, age 38, who following alcoholic excess developed signs and symptoms of acute pancreatitis. Blood amylase was 410. Electrocardiograms revealed T wave changes and T wave inversions in leads 1, 2 and 4. The heart clinically sounded normal but the electrocardiograms were interpreted by the cardiologist as indicative of coronary thrombosis. The patient recovered and subsequent electrocardiograms appeared normal.

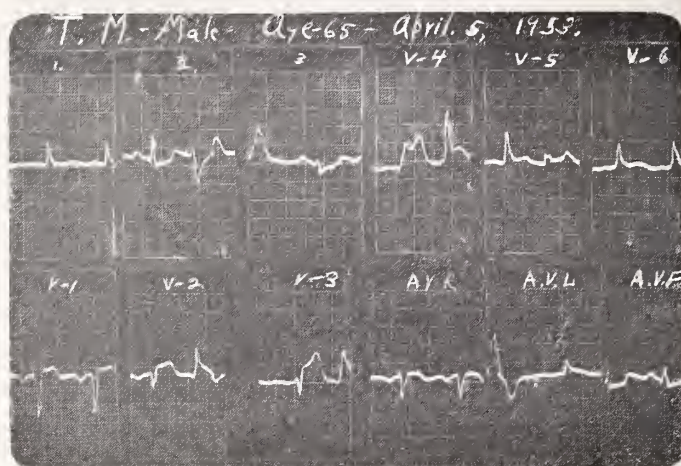
The most interesting case however discussed by these men was that of a woman, age 68, who entered the hospital with abdominal distension and prostration. There was cyanosis, shock, pain and distended veins. Gallup rhythm was present. The blood pressure was 50/40. The electrocardiogram showed sinus tachycardia, a small Q<sub>1</sub> and a deep Q<sub>2, 3, 4</sub> with R T elevations in all the leads. T<sub>1</sub> showed low voltage. These changes were interpreted as characteristic of an acute myocardial infarction. The clinical diagnosis of acute myocardial infarction was also made. Death occurred three hours after admission. Autopsy revealed acute pancreatitis. The coronary arteries were patent throughout and there was no evidence of myocardial infarction. Gottesman, Casten and Beller did animal experiments in order to bring out electrocardiographic changes that were due to acute pancreatitis. They caused acute pancreatitis in dogs. In all the dogs in which acute pancreatitis was experimentally produced distinct aberrations of the electrocardiograms were observed. At autopsy, in none of the dogs were there evidences of myocardial infarction or myocardial damage.

We wish to present the two cases of the writer's recent experience which had acute upper abdominal disease and which developed electrocardiographic changes simulating recent myocardial infarction.

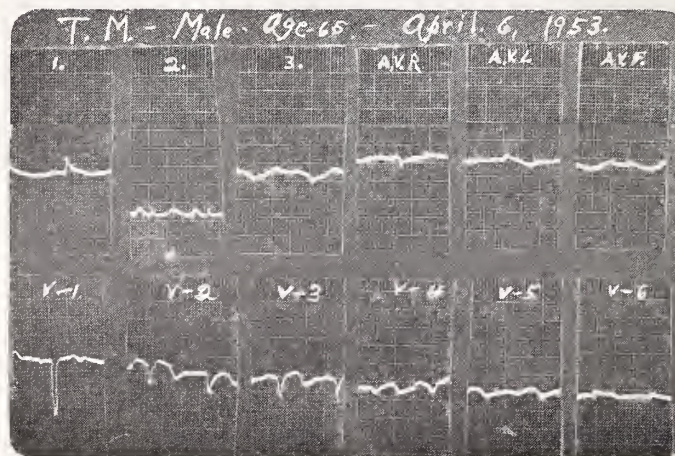
The first case is T. M., age 65, male who was admitted to the Manchester Memorial Hospital on April 5, 1953 at 4:45 P. M. The patient complained of high epigastric pain which began in the morning while he was in church. This pain gradually grew worse and he called his family doctor who admitted him to the hospital. History taken on admission revealed that for the past three years he was distressed by substernal pain following exertion. He also told of frequent

heart burns for which he had been treated. No G.I. x-ray series had been done.

Physical examination at the hospital revealed a boardlike rigidity of the upper part of his abdomen. Serum amylase on admission was over 1100 units.



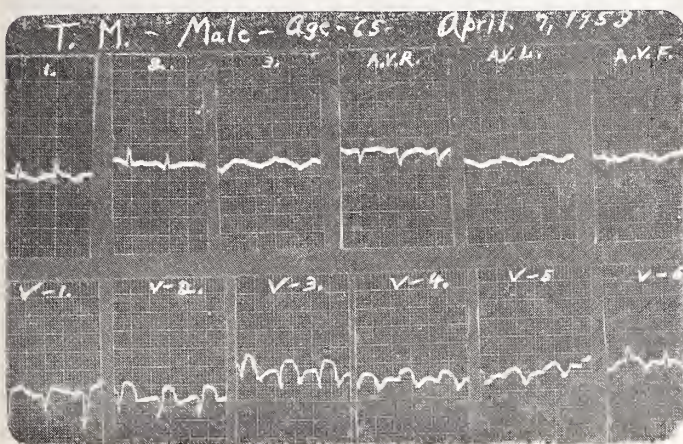
The electrocardiogram taken at this time as seen above revealed many premature ventricular beats. There is depression of S T in leads 2 and 3. There is a Q S present in V<sub>2</sub> and elevation of S T in V<sub>1, 2, 3, 4, 5</sub>. S T is elevated in A V L and depressed in A V F. An electrocardiographic diagnosis of recent anterior myocardial infarction was made. A diagnosis of acute hemorrhagic pancreatitis was also made. The patient was not seen by the cardiologist and only the electrocardiographic reading was transmitted to the chart. On April 6 the patient seemed a bit worse. His temperature gradually began to climb from 100° rectally until at 12:00 midnight it was 104.6°. His pulse rose steadily from 100 to 145 at 12:00 midnight. A serum amylase done the next day again was over 1100 units.



An electrocardiogram taken on the morning of April 6 seen above reveals that changes have taken place. There is now elevation of S T in lead 1 with some inversion of the T wave. S T is depressed in lead 3. S T is elevated in A V L and T is inverted in A V L. S T is depressed in A V F. There is now a Q S in V<sub>1, 2, 3</sub>. S T is elevated in V<sub>2, 3, 4, 5, 6</sub> and T is inverted in V<sub>2, 3, 4, 5, 6</sub>. It would appear from the above electrocardiogram that there was extension of a recent anterior myocardial infarction. At 8:00 P. M. on



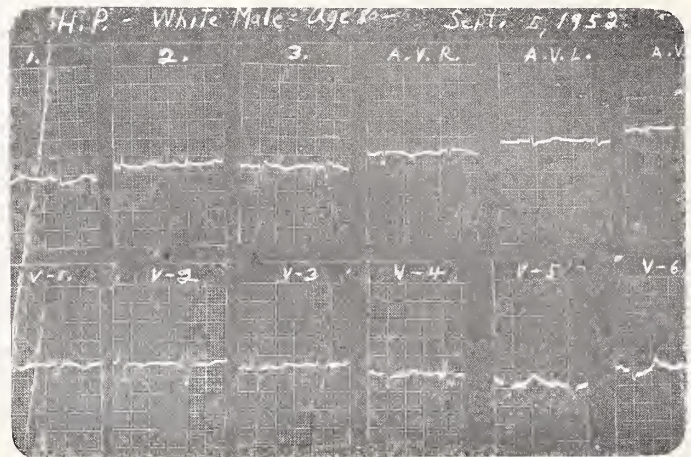
April 6, 1953 a consultation was held at the request of the patient's family doctor. The surgeon and the cardiologist were present. It was quite apparent that the patient was critically ill. His pulse was rapid, around 125. His temperature was  $103.4^{\circ}$  rectally and his respirations were now around 40. The upper part of his abdomen showed board-like rigidity. The patient showed all the other criteria for acute hemorrhagic pancreatitis such as elevated blood sugar and as stated previously very high serum amylase. Examination of the heart revealed a typical to and fro pericardial friction rub and yet clinically the patient did not appear to be dying because of the cardiac condition. In fact he did not appear clinically like one who had had a recent myocardial infarction. It was felt as a result of the consultation that he was suffering from acute hemorrhagic pancreatitis and this was primarily the cause of his poor condition. There was now a doubt as to whether he had had a recent myocardial infarction because of his clinical appearance. On April 7, 1953 the patient seemed worse. The serum amylase was still over 1100. The blood calcium was 3.3 millequivalents.



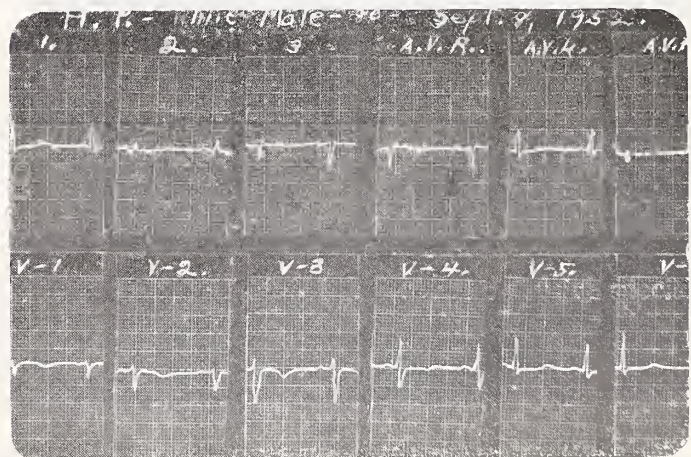
An electrocardiogram taken on the morning of April 7 as seen above reveals T is more deeply inverted in lead 1 than in previous electrocardiogram. ST is still depressed in lead 3. ST is elevated in A V L and depressed in A V F. There is a Q S in V 1, 2, 3 and there is marked elevation of ST in V 2, 3, 4, 5. T is inverted in V 2, 3, 4, 5, 6 and it will be noticed that T is more deeply inverted in V 6 than in the previous electrocardiogram. The ST's show upward coving in V 2, 3, 4, 5. The patient gradually grew worse and expired on April 7, 1953 at 5:30 p. m. An autopsy was done and this revealed a diffuse acute hemorrhagic pancreatitis. There was an old anterior myocardial infarct which covered an area equivalent to the area of suspected damage as seen on the electrocardiograms. This area was over the anterior lower part of the left ventricle and somewhat lateral. There was a thinning of the myocardium just above the apex. Over the area of old infarct there was a localized circumscribed fibrinous pericarditis.

The next case is H. P., age 80, male, white. This patient entered the Manchester Memorial Hospital on August 25, 1952 at 2:45 p. m. He was complaining of right lower quadrant pain for four days. He had vomited and had diarrhea for three days. On admission his temperature was  $100^{\circ}$ , his pulse 76 and his respiration 20. His blood pressure was 138/86.

He showed right lower quadrant tenderness with minimal spasm. His white count was 13,150. On August 26, 1952 an appendectomy was performed. Pathological diagnosis of the specimen was chronic obliterative appendicitis. Postoperatively the patient did not do well. His temperature ranged around  $100.6^{\circ}$  and then on the ninth postoperative day it went up to  $101.6^{\circ}$ . He complained of some upper abdominal pain and chest pain.



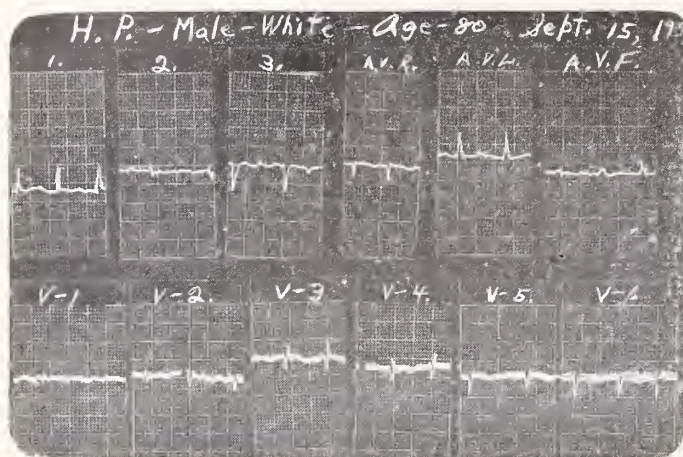
An electrocardiogram was taken on September 5 which can be seen above. There is depression of the ST in lead 1 and elevation in lead 3. A Q S is present in lead 3 and T is inverted in lead 3. There is slight depression of ST in A V L and elevation in A V F. There is an abnormally appearing Q wave in A V F. T is inverted in V 1, 2, 3. ST is slightly depressed in V 4, 5, 6. Since no electrocardiogram was taken before the operation there was none present for comparison. The above changes were thought to be due either to a pulmonary embolus or a recent posterior myocardial infarct. The patient's temperature gradually subsided and he seemed improved.



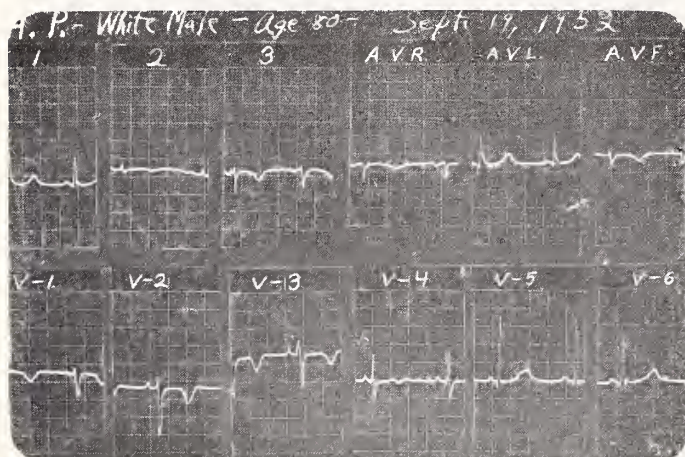
A second electrocardiogram was taken on September 8 which can be seen above. ST is no longer depressed in lead 1 nor elevated in lead 3. T is still inverted in lead 3. T is flat in A V F and there is now a small R and S wave in A V F. T is more deeply inverted in V 2, 3, 4 than in the previous electrocardiogram. It was felt that the changes in this electrocardiogram were probably due to pulmonary embolus. He did fairly well until September 10 when he began to have



temperature that rose as high as  $103^{\circ}$ . On September 11 he showed extreme right upper quadrant tenderness and elevation of the temperature up to  $103^{\circ}$  and an elevated white count. It was felt at that time that he had an acute cholecystitis but operation was delayed because of the electrocardiographic findings. He was therefore treated conservatively and placed on antibiotics. His right upper quadrant pain gradually subsided.

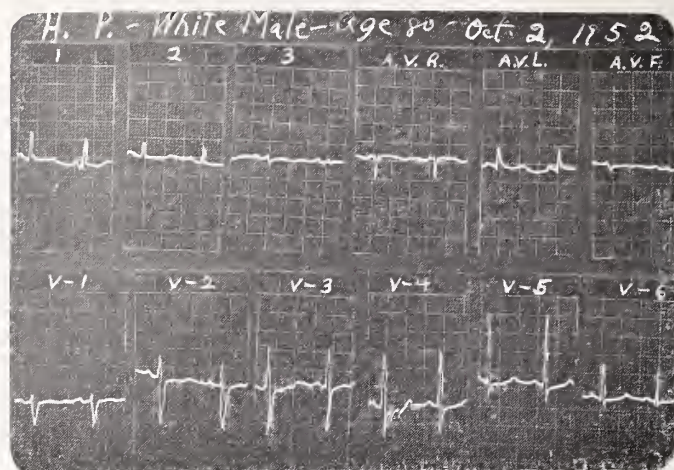


On September 15 another electrocardiogram was taken which can be seen above. Auricular fibrillation was present and the ventricular rate 104. Changes had taken place in the electrocardiogram and it can be seen that there was now an abnormal Q wave in V 3, 4, 5 and there appeared to be a Q S wave in V 6. S T was elevated in V 3, 4, 5, 6 and there was inversion of the T wave in V 3, 4, 5, 6. It was felt from this electrocardiogram that a recent anterior myocardial infarct had taken place. Patient's temperature again subsided. He seemed to be doing nicely.



On September 19 another electrocardiogram was taken as can be seen above. Normal sinus rhythm is present. T is inverted in leads 2 and 3. There is a deep S wave in lead 3. T is inverted in A V F and there is a deep S wave in A V F. T is deeply inverted in V 1, 2, 3 and biphasic in V 4. The T waves are definitely abnormal in this electrocardiogram but are nonspecific in nature. The Q waves and S T elevation have disappeared. The patient continued to do fairly well. However, by September 26 his white count again became elevated. He had pronounced symptoms of right upper

quadrant pain, tenderness and spasm and on September 27, 1952 he was operated upon and a cholecystectomy was performed. A culture of E coli was obtained from a distended gall bladder. There were several mulberry shaped stones within the gall bladder. The patient seemed to do fairly well following the operation.



On October 2 another electrocardiogram was taken which may be seen above. It can be seen that the electrocardiogram is gradually reverting to normal. The deeply inverted T waves in V 1, 2, 3 are no longer present and there is very slight inversion of the T in V 1, 2. The T is still inverted in lead 3 but not inverted in lead 2 as in previous electrocardiogram. There are no abnormal Q waves or S T elevations and depressions. On October 6, 1952 the patient developed a phlebitis in the left leg and was given anticoagulants for this. Three days later he developed massive G I hemorrhage and went into shock. This was treated with multiple transfusions and was stabilized for a while. His prothrombin time was returned to normal with vitamin K. The patient continued to have G I bleeding and died on October 16, 1952 in spite of all treatment. Autopsy revealed a bleeding duodenal ulcer. The heart and lungs were entirely negative.

#### DISCUSSION

It can be seen that a review of the literature reveals and our experiences indicate that many extra cardiac factors may produce symptoms of coronary artery disease and electrocardiographic changes that simulate recent myocardial infarction. In most of the cases in the literature the electrocardiographic changes that simulated myocardial infarction were non specific, that is, there were no Q waves but there were S T and T wave changes. In one case, however, the electrocardiographic changes were specific in nature, that is, there were deep Q waves and S T elevations. In the two cases admitted to the Manchester Memorial Hospital there were specific electrocardiographic changes, that is, abnormal Q waves, S T elevations and depressions and T wave inversions. Since S T elevations and Q waves appear with rare exceptions only in recent myocardial infarction



then it can easily be seen that in cases presenting themselves with acute upper abdominal disease and electrocardiographic findings simulating recent myocardial infarction, a definitive diagnosis must be approached with extreme caution. Sometimes only time will tell as to whether the electrocardiographic changes were specific or non specific in nature and sometimes certainty as to the cause of the electrocardiographic changes may only be proved by autopsy.

CONCLUSION

Extra cardiac disease may cause electrocardiographic changes. Most of the time extra cardiac diseases when they cause electrocardiographic changes cause non specific electrocardiographic changes, that is, S T and T wave changes. Occasionally extra cardiac diseases may cause specific electrocardiographic changes, that is, abnormal Q waves, S T elevations and depressions and T wave inversions and these specific changes seem to indicate that a recent myocardial infarction has taken place. Among the more important extra cardiac diseases that may cause electrocardiographic changes are acute upper abdominal lesions. When acute upper abdominal lesions such as acute cholecystitis with cholelithiasis, duodenal ulcer, perforated ulcer and acute pancreatitis cause electrocardiographic changes

simulating recent myocardial infarction, it becomes very difficult to be sure as to whether the patient has suffered either an acute upper abdominal catastrophe, a recent myocardial infarction, or both.

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SECONDARY GLAUCOMA IN ONE-EYED PATIENTS

Two Unusual Cases

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GLAUCOMA is usually divided into primary and secondary. The primary type of glaucoma is that to which no definite etiology can be assigned. The secondary is that in which a cause is known. Many cases of primary glaucoma are, with careful studies, being resorted and reclassified into secondary types.

CASE 1

On December 2, 1952 Mr. A. B., a 44 year old white construction worker, was referred to the Eye Clinic of New Haven Hospital for eye emergency consideration. He had a childhood injury to the right eye which has been complicated by a low-grade glaucoma. One year prior his visual acuity

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SUMMARY

Two cases are reported of one-eyed patients with secondary glaucoma, who, despite a very poor prognosis, have been able by careful preoperative studies and wise selection of operation to maintain the little residual vision they possessed. In both these cases the livelihood of the patient as well as his family depended upon careful treatment and operation.



was 20/30 and on admission was 20/200. His tension fluctuated from normal to extremely high. Four per cent pilocarpine, 0.5 per cent eortone, and cod liver oil every two hours controlled the tension fairly well. The left eye was injured in England during his war service. The sight was completely obliterated by a large corneal scar. The patient had been referred to the Veteran's Administration and was not acceptable there on the basis of lost records. He was sent to the Boston Eye and Ear Infirmary for consultation and a cyclodialysis or cyclodiathermy was recommended to control the tension in the right eye and a full thickness corneal transplant of the left eye was considered. A doctor in Hartford in charge of Public Welfare insisted that this work be done in Connecticut.

The patient was admitted on January 15, 1953 because of a misunderstanding. Further history obtained from him showed he had had an iridectomy or an iridencleisis of the right eye following trauma at age 9. His complaints were that he had halos, nausea, headache, and extreme loss of vision of the right eye. Pressure on this admission showed a severely damaged cornea with finger tension of 4 plus. His son had "eyes like his daddy" and showed iris defects congenital and marked astigmatism but normal tension.

On January 17 a cyclodiathermy and paracentesis of the right eye was performed. The lids were sutured. The paracentesis was opened on several occasions while in the hospital to relieve the recurrence of tension. Visual acuity was 4/200 on January 20. On January 31 the patient was seen by Dr. Edmund Spaeth of Philadelphia who happened to be visiting in New Haven. At this time his pressure was again elevated. His vision was 5/200 and an Elliott trephine was suggested by Dr. Spaeth.

On February 2 an Elliott trephine was performed without incidence. On February 20 it was noted that his vision was 8/200 in the right eye. Finger tension was normal and slit lamp examination showed again severe epithelial damage with staining with fluoresceine. No endothelial disturbance and no flare were noted. Seen on repeated occasions the cornea was always noted to have large bullous-like blebs and never any endothelial changes. The operative bleb continued to work and finger tension continued normal.

On repeated occasions the corneal epithelium was removed, curetted, and touched with 2 per cent tincture of iodine or silver nitrate in an effort to cause regeneration of the epithelium. The corneal epithelium continued to break down despite bandaging, all medications, including neosone, cod liver oil, and huge doses of vitamins. The patient was seen by Dr. E. M. Blake and no further suggestions could be offered.

Vision continued at the 3/200 to 5/200 level. Bullae continued to reform. On July 22 the patient could only count fingers at 4 feet. Finger tension continued normal and the eye continued to irritate him but he did not have the associated nausea and vomiting he had when he was referred. It was felt that it was undesirable to apply the tonometer in view of this bullous keratitis and recurrent epithelial breakdown over a period of several months.

On May 25 another large bulla was removed and the patient remarked that he could see a fly on the wall. Without correction and with complete removal of all the epithelium

under pontocaine anesthesia his vision was 20/60. His tension was 17.

On October 14 the epithelium again stained, finger tension was normal. He was seen that same day by Dr. David Cogan of Boston who was visiting New Haven. Although he was unable to see the patient under the slit lamp he had no suggestions as to what to do about the recurrent epithelial breakdown.

This case represents what all who had seen this patient felt was a secondary type of glaucoma, secondary to congenital defects and trauma. The unusual aspect is the recurrent breakdown of the epithelium for which nothing to date has been successful, even though the tension has been made normal.

## CASE 2

Mr. J. S., age 34, was referred to the Glaucoma Clinic in the New Haven Hospital on June 9, 1952 as a therapeutic problem. The patient was a 34 year old white male with a history of congenital lues and associated bilateral interstitial keratitis as a child. He had had considerable antiluetic treatment. He showed corneal infiltrates of the left eye and the right eye. Increased tension in both eyes with deep cupping of the right eye was also shown. His left eye had a good red reflex but the fundus was not seen because of corneal scarring, bulging, and edema. The left eye was exotropic. Vision was 20/30 in the right eye with a minus 5 sphere combined with a minus 150 cylinder axis 15. There was absent light reflex on the left. The patient showed a Schiötz tonometer reading of about 36 O.D. on each visit despite 4 per cent pilocarpine five times a day. His miosis was good. He had not used florapryl up to this point. It was felt by the referring doctor that surgery would be required to prevent further field loss.

Vision on admission on June 13, 1952 was 20/70 in the right eye without correction and 20/40 with correction. There was no light perception in the left eye. Tension with the electronic tonometer in the right eye was 39 and in the left was 5. At that time the patient was on 4 per cent pilocarpine four times a day and 0.1 per cent florapryl at bedtime. In the right eye there was an impression of edema of the iris or a "physiological iris bombe." The patient was dilated cautiously with 10 per cent Neosynephrine and Paredrine and the pressure fell to 32 or 34 mm. on the electronic tonometer.

Fundus examination showed a very large deep glaucomatous cupping with the vessels pushed far nasally. No flares nor cells were noted in the right eye. They were noted in the left eye. Both corneas showed "ghost vessels." The angle gonioscopically was wide with the trabeculae well noted. The slit lamp showed a clear lens in the right eye. There was a small area of atrophy at 3 o'clock on the iris of the right eye. The patient was told to discontinue all medications for 24 to 48 hours and to have a repeat tension. Since the trabeculae were open and since there was a good angle and a suggestion of a "physiological iris bombe" as described by Chandler, it was planned to do an iridectomy.

Field examination of the right eye with his correction,

using a 3 mm. white test object at 330 mm., showed an enlarged blind spot and a field extending above to 20 degrees, temporally to 70 degrees, inferiorly to 40 degrees, and medially to 20 degrees with a suggestion of a nasal cut. Central field examination of the right eye, with his correction, using a 3 mm. white test object showed a Roene-like step extending below to 25 degrees and above showed a very large defect.

Seen in consultation on March 5 with Dr. Eugene M. Blake, it was the latter's impression that there was an "iris bombe" type of iris present. He felt that this represented a secondary type of glaucoma, secondary to syphilis.

On March 6 the patient had a basilar type of iridectomy done with a preoperative plan to accomplish two things, (1) to preserve the sphincter, and (2) at the same time to tear the iris deep in the base. It was hoped by preserving the sphincter to permit the better action of constrictor drugs, should this be necessary. The diagnosis at no time had been clear as to whether this was a primary or secondary type of glaucoma. Unfortunately the iris biopsy was lost. At the end of the operation the wound edge was approximated with a 6.0 silk and 2 per cent atropine solution was instilled.

On the second postoperative day the patient saw well but on the third said that he was unable to see from his one remaining eye, the right. No evidence of lens damage or any explanation for this could be found under the slit lamp. Finger tension was normal. The patient was placed on 4 per cent homatropine, sodium sulfacetamide, and neosone ophthalmic ointment. Later in that day the patient said he again could see and in talking it over with his former physician it was felt that the apparent blindness was hysterical.

The following is a follow up report from the patient's referring ophthalmologist: March 12, 1953—Basal iridectomy with preserved sphincter, O.D. March 6, 1953. Vision O.D. with correction, minus 5.00 S minus 1.50 cx 15, plus pinhole 20/200. Slight edema upper right lid, O.D. moderately injected, some corneal edema, fair dilatation, lens appears clear, good red reflex, fundus details not well seen because of corneal edema, no separated choroid, tension to fingers very soft. March 16, 1953—Tension nearer normal today, less edema of cornea, fundus seen better, cupping and atrophy of disc and scattered pigment as before. Vision with correction plus pinhole 20/70 minus 1. March 26, 1953—Vision with correction 20/70 minus 2, with pinhole 20/50 minus. Apparently patient will need more minus cylinder. Tension O.K. April 4, 1953—Vision with correction 20/40. Tension 30 Schiötz. May 16, 1953—Vision with correction 20/50 minus 1. Tension 25 Schiötz. August 22, 1953—Refraction. Minus 5.00 S minus 3.50 cx 10. Tension 25 Schiötz. 20/40 minus 1. October 24, 1953—Tension 25 Schiötz. Vision with new correction above 20/40.

This case is unusual in that merely an iridectomy combining tearing at the base of the iris has made his tension normal and maintained his visual acuity and field to date.

In addition to the referring physicians I should like to extend my thanks to Dr. Andrew Wong, Dr. Louise Lovekin, and Dr. Harold Patterson for their pre and post operative help with these patients.

## PRIMARY ADENOCARCINOMA OF THE APPENDIX: REPORT OF TWO CASES

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### SUMMARY

Two cases of primary adenocarcinoma of the appendix are described and discussed.

THE relative rarity of primary adenocarcinoma of the appendix, especially prior to 1940, is interesting to note and difficult to explain. One explanation which suggests itself is that the early reliance on gross examination alone may have failed to identify some of these tumors. With the replace-

ment of this substandard practice by full examination, many more of these tumors are now being discovered.

Much of the early statistics are of little value, since the earlier workers made no clear distinction between the various types of tumors of the appendix, such as carcinoid, mucocoele, and primary adenocarcinoma of the colonic type. Also many of the early cases were reported as appendiceal carcinoma when the tumor involved both cecum and appendix, even though there was no clear evidence of origin in the appendix rather than in the cecum. Young and Wyman<sup>1</sup> pointed up this important distinction and reviewed the literature, finding only four acceptable cases to which they added one of their own. Uihlein

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and McDonald<sup>2</sup> reviewed the experience of the Mayo Clinic and found five cases over a thirty-one year period; these comprised only 3.5 per cent of their cases of appendiceal neoplasm, which included 127 cases (88.2 per cent) of carcinoid tumor and twelve cases (8.3 per cent) of cystic tumors (i.e., the so-called malignant mucocele). Lesnick and Miller<sup>3</sup> reviewed the problem in 1949 and reported on five cases.

Since these reports there have been many papers reporting new cases singly and in groups up to five. Recently Sillery<sup>4</sup> compiled 116 reported cases, to which he added two more; and since his paper, several more cases have been added.<sup>5,6</sup> Most of these are clearly true cases of invasive primary adenocarcinoma of the appendix.

#### REPORT OF CASES

##### CASE I

F. M., a 61 year old, white female was admitted to the New Britain General Hospital with a history of intermittent right lower quadrant pain of five weeks' duration. Physical examination showed severe lower abdominal pain and tenderness. Laboratory studies showed a leukocyte count of 11,000 per cu. mm., with 81 per cent polymorphonuclear leukocytes. A laparotomy was performed and an apparently acutely inflamed appendix was removed.

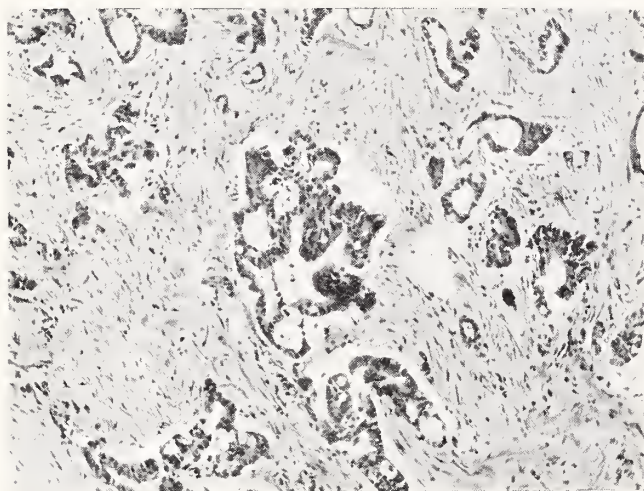


FIGURE 1

Adenocarcinoma of the appendix invading muscularis in Case I

The surgical specimen showed the appendix to have a thickened, firm, gray fibromuscular wall and a small lumen. Some mesoappendiceal fat was included and this showed a circumscribed area of homogeneous light gray tissue, 0.8 cm. in diameter. Microscopic examination showed malignant tumor of epithelial and glandular type; the neoplastic glands

were imperfectly formed and showed loss of polarity, mitoses, and large, atypical nuclei. Outside the area of tumor the appendix showed necrosis and polymorphonuclear infiltration characteristic of acute appendicitis. The small mass of tissue in the mesoappendiceal fat was seen to be a metastatic adenocarcinoma in a lymph node.

On the twelfth hospital day a second laparotomy was performed and 16.0 cm. of terminal ileum, cecum, and 20.0 cm. of ascending colon were excised with their mesenteries. Laboratory study of this specimen showed some remnants of

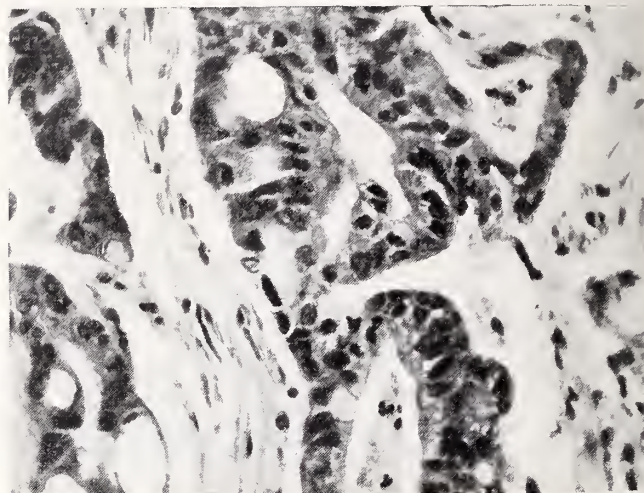


FIGURE 2

High magnification of tumor, Case I

carcinoma in the appendiceal stump, not involving the cecum proper, and metastatic tumor in two out of twenty-five mesenteric lymph nodes studied.

After the second operation the patient did well for several days when a left hemiplegia suddenly developed. After slight clinical improvement a second cerebrovascular accident led to her death thirteen days after the second operation. Autopsy permission was refused.

##### CASE II

F. B., a 71 year old, white male was admitted to the New Britain General Hospital with a six day history of malaise and anorexia and three days of abdominal pain, which was periumbilical initially, but later was worse with localization in the right lower quadrant. Physical examination showed extreme right lower quadrant tenderness, with rebound tenderness and depressed peristaltic sounds. Leukocyte count was 14,650 per cu. mm., with 81 per cent polymorphonuclear leukocytes and 4 per cent immature neutrophilic granulocytes ("stab forms").

At operation the surgeon found a large, bulky appendix which "looked peculiar," but was apparently acutely inflamed. Gross examination showed thickening and loss of the usual architectural details, involving all but the proximal 2.0 cm. of the appendiceal wall, and perforation at the tip. Microscopic examination showed necrosis and polymorphonuclear infiltration at the tip, and invasive tumor replacing



most of the mucosa at the midpoint. The tumor cells formed papillary masses and small, irregular glands, and grew into the muscularis as short cords of undifferentiated cells with large, pleomorphic, hyperchromatic nuclei. Tumor cells were seen in the lymphatic channels in the outer part of the wall, and extended to the line of excision on the mesoappendiceal border. The proximal 1.7 cm. of the appendix was free of tumor.

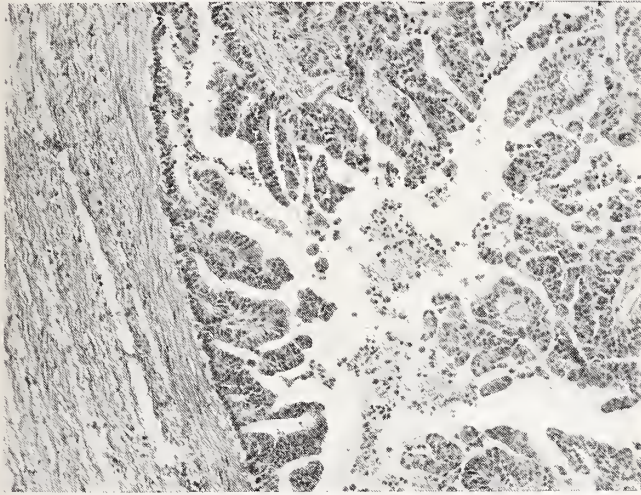


FIGURE 3

Papillary adenocarcinoma of the appendix, Case II

A second operation was performed eleven days later, and a specimen consisting of 15.0 cm. of ileum and 12.0 cm. of cecum and ascending colon with attached mesentery was resected. Continuity of the bowel was reestablished with an end-to-side ileocolostomy. The specimen showed an abscess in the bowel wall and mesentery adjacent to the appendiceal stump, and in the mesenteric fat a single cluster of neoplastic cells. Twelve lymph nodes were examined, and one of these showed similar tumor. There was an interesting incidental finding of melanosis coli.

The patient withstood the operation very well and was discharged in good condition. At the time of writing, sixteen months after operation, he is living and well.

Grateful thanks are due to Dr. William Watson for permission to report these cases, and to Dr. Paul Rosahn for many helpful suggestions.

#### DISCUSSION

These two cases presented as acute appendicitis, with history, physical examination, and labora-

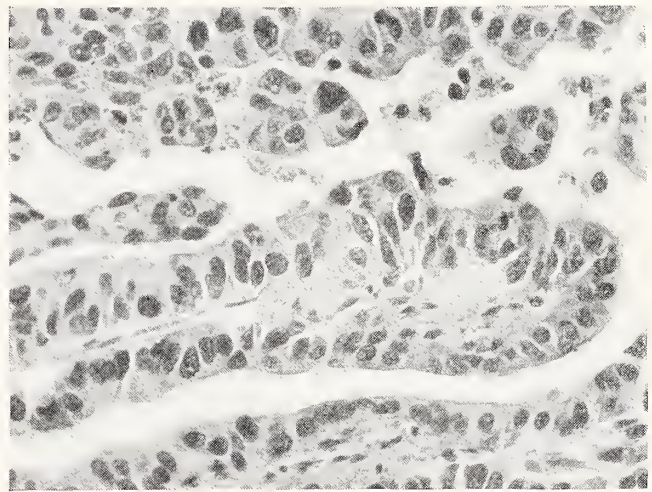


FIGURE 4

High magnification of tumor, Case II

tory findings consistent with this diagnosis. In each case the surgeon felt that this diagnosis was supported by the operative findings. Only when the specimen was carefully examined in the laboratory did the true nature of the lesion become evident. In the first case the diagnosis was unsuspected until the microscopic slides were examined, but in the second case the gross appearance was suggestive enough to lead the pathologist to obtain a preliminary finding by frozen section.

In each case the tumor was of the colonic adenocarcinoma type, and in each case it was confined to the appendix and associated lymph nodes.

The primary adenocarcinoma of the appendix usually presents as an acute appendicitis because it is just that; the acute process is set up by the obstructive nature of the lesion, and the sequence of events is the same as that which leads to any appendicitis from obstruction. There are no specific diagnostic points by which the disease can be identified pre-operatively, and the diagnosis is generally made on pathological examination.

It is entirely possible that in some cases an appendectomy may excise the entire tumor, and further therapy may be unnecessary. In neither of the cases presented was this true, since tumor was



seen at the limits of excision, suggesting incomplete removal, and tumor was found in the ileocelectomy specimen removed at later operation. It is generally conceded that partial ileocelectomy is the safer course, even when the tumor has apparently been completely removed by the original appendectomy.

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## CONNECTICUT CIVIL DEFENSE MEDICAL SERVICES

EDGAR B. PROUT, M.D., *Hartford*

**M**ODERN atomic war is war at home. The enemy attack will be directed to the destruction of military installations, essential industries, especially the war industries, and the centers of large population concentration.

There have been designated by the Federal Government 70 critical target areas in this country. The critical target map shows Connecticut is the state most nearly covered completely. There are five critical target areas designated in this State; Hartford, New Britain-Bristol, Bridgeport, New Haven and Waterbury. The Stamford-Norwalk area is listed as a target area, but not as a critical one. New London has been added by the State because of the installations there. Consequently, the civil defense planning for the State is formulated to a great extent for the protection of these target cities where there are war industries and the greatest concentration of population.

The medical services are planned, both for self help as much as this can be provided, with aid coming to the target city chiefly from the surrounding communities that have been designated as mutual aid areas, and to render, as well, help to another area if the target city itself is not struck. This mutual aid extends beyond the State boundaries through an arrangement with the six New England States, New York and New Jersey, who have a mutual aid compact.

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The Author. *Chief of Health Services, State Office of Civil Defense*

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#### SUMMARY

This is a discussion of the possibilities encountered should atomic warfare come home to Connecticut. The various target areas in this industrial State are delineated and the effects to be expected from modern bombing of these areas described. The medical services planned to meet such an emergency are described. Emphasis is placed on the need for preparation even though the catastrophe may never come.

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The Federal directives have assumed that a 2½ (X) bomb will probably be used. This is equivalent to the explosive power of 50,000 tons of TNT. It is recognized that bombs of greater power or possibly the "H" bomb may be used. The 1 (X) bomb used in Hiroshima and Nagasaki was equivalent to 20,000 tons.

By extensive studies of the effect of the Japanese bombings, estimates of the number of deaths and the injured have been made. These studies have considered the difference of types of buildings, our warning systems and population concentrations in this country, as compared with those in Japan.

The peak daytime populations of the target cities have been estimated in several ways: by count;

Chambers of Commerce reports; personnel records of the war industries; and from statistics of the State Labor Department. The cities have been divided into districts and the percentage of deaths and injured are calculated in these districts in their relation to ground zero.

Grossly the number of deaths in target areas is assumed to be about one-fifth of the population there, and the injured approximately one-sixth.

In general the type of injuries, it is considered, will be 60 per cent burn cases (thermal and radiation), 50 per cent mechanical injuries, and 20 per cent radiation exposures. Many will have more than one type of injury which accounts for the more than 100 per cent. For the purpose of treatment and hospital designation, a further division is made. Approximately one-third of the cases can be treated on an outpatient basis; approximately one-third of the less seriously injured, Class B, will require moderately prolonged and moderate extensive hospital care; and one-third will require urgent care in established general hospitals or emergency hospitals. These latter are considered to be as Class A cases. They are further divided into: Group 1, about 10 per cent, who it is considered will be so severely injured that they will not recover by any means of treatment; Group 2, about 20 per cent, who will require urgent surgery in general hospitals outside of the target city; Group 3, about 20 per cent, those cases in which surgery can be safely delayed to some extent; Group 4, 40 per cent, who will have extensive burns that will not require immediate surgery but must be treated for burns and shock; Group 5, about 10 per cent, who will require observation and study before treatment is instituted—these are chiefly those exposed to considerable radiation. Groups 3, 4 and 5, can be cared for in the miscellaneous hospitals, such as public institutions and convalescent homes, or in improvised hospitals.

The one-third, Class B cases (those less seriously injured) can be at least temporarily cared for in the casualty stations that serve for first aid, triage and as secondary hospitals. These stations are to be located  $3\frac{1}{2}$  to 4 miles from ground zero and selected where there are ample water supplies, heat and floor space to accommodate 200 bed cases.

The number of surgical and medical teams required is determined by the number of cases of each type and by the number of cases each of these teams can be expected to care for during the emergency period.

The Connecticut State Department of Health has recently made a survey of all the available hospital beds and the State Civil Defense Office has listed these in a manner by which the number of available emergency beds in general, miscellaneous and improvised hospitals can be quickly found, as they are listed in each area. From this survey the direction of the cases for the immediate surgical care and for medical care can be readily made.

The field teams are set up to serve in the bombed area after the attack. These consist of first aid groups and litter bearer groups. Although not in the Federal plan, it is the opinion of the State Office that one physician should accompany each large group so that the immediate transfer of the most urgent cases can be made from the field.

It is in the field service that the most intimate contact with the other divisions of civil defense is made. The Highway Department is responsible for the clearing of the main highways leading into the bombed area and those on the periphery connecting the medical stations. It is planned that the fire departments, police, wardens and rescue groups, communications, welfare, transportation and those responsible for the public utilities cooperate and coordinate their services. The special weapons defense, such as the identification of the chemical and biological agents and decontamination, and radiation monitoring, are parts of the medical services that enter into the general planning, as well as that of the special blood program.

Medical supplies have been procured and stored in the State. There are 202 first aid units that have been designed by the Federal Government for the minimum supplies necessary to care for 500 casualties. The emergency hospital supplies are being assembled by the Federal office. These are designed to provide the materials in a hospital unit for a 200 bed emergency hospital. There are extensive special and reserve Federal supplies, for the northeastern region, stored at Ellenville, New York, and Gilbertville, Massachusetts, which are available for use in the State.

A good library of information on the medical aspects and services in civil defense has been established in the State Office. This has been developed from releases and bulletins from the Federal Civil Defense Administration; studies by several states; and from bulletins prepared by the State Department of Health, of which there are 18, with one on biological warfare recently completed.



This will give an idea of some of the things that have been done, and what has entered into the planing for medical services.

The details of the studies are contained in the operational plan and in the analyses of the facilities and medical personnel requirements that have been made for each area.

The general Fairfield area has been divided into three sectors for operational purposes. The major services have been designed to protect Bridgeport, the principal target city.

It is considered necessary that Stamford, Norwalk, Greenwich and Danbury have medical services planned for self aid, as well as for mutual aid. The details for these are outlined in the operational plan for the area.

If the City of Bridgeport is struck, it is estimated that about one-sixth of the population in the disaster area, approximately 35,000, will be injured; and that about one-fifth, approximately 42,000 will be killed.

The resident population of Bridgeport, as of July 1, 1953, was 165,400; the peak daytime population, as estimated by the State Labor Department, is 210,000. The calculations of the numbers of casualties are based on the peak population.

The number of surgical teams required for the emergency is estimated as 184; the number of triage teams working with the surgical groups as 23. These are to care for the acute surgical cases.

The number of medical teams required is 82. They are to treat those not requiring urgent surgery, such

as burns, shock, minor wounds and fractures, and others.

The minimum number of physicians and surgeons required for the emergency services in the Bridgeport area is considered to be 432; the number of dentists, 244; and the number of nurses, 964. There are 871 physicians, 415 dentists and 3,038 nurses registered in the Bridgeport area.

The total mobilization of all available medical personnel is necessary if the unprecedented demands of the medical services are met even reasonably well. Preparation for this should be carried out without delay and full voluntary cooperation is needed for satisfactory operation of this overall plan. It is the responsibility of the local community to protect and care for its own people with the cooperation and help of the State and Federal Civil Defense Administration.

If by some good fortune we are not called upon to render such service, little will be lost; but the losses, without planning and the readiness to serve, will be great, perhaps even more than we have estimated, if we are not prepared.

It is assumed that with adequate warning of an impending raid, good public discipline and cooperation, the overall daytime casualties would be reduced by approximately one-half. The number of lives saved would be approximately in the same proportion, if proper care of the injured can be given through well planned, well organized medical services.

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## EDITORIALS

### The 162nd Passes Into History

The 1,900 physicians of Connecticut who did not find it possible to attend any of the sessions of the 162nd annual meeting held in Hartford the last week in April missed a real treat. We feel quite certain that the 984 physicians who did attend will agree that it was one of the finest sessions our State Society has ever enjoyed. We were privileged to be hosts to 146 guests and enjoyed the friendly presence of 227 exhibitors.

The Program Committee and the Committee on Arrangements deserve great credit for arranging an excellent program and carrying it through with a finesse which was appreciated. The general sessions meeting in the auditorium of Bulkeley High School afforded an unusual assortment of subjects presented by outstanding experts from large medical centers in the eastern section of the United States and Canada. There was a symposium on biliary tract disease and another on diabetes, as well as a panel discussion on dysphagia and heartburn. The various specialties held their section meetings, addressed in most instances by guest speakers. Many of the specialty and auxiliary societies also met during the two days of the scientific program. The Woman's Auxiliary convened its annual session at nearby Trinity College.

It is Hartford Hospital's centennial this year. One of the afternoon programs of the State Society meeting was given over to a short historical presentation of the Hospital, interesting anecdotes connected with its family life, and a clinical pathological conference

put on by members of its staff. Then at the annual dinner John C. Leonard, director of medical education at the hospital, took over after the presentation of the 50 year membership awards and papers were read on "The Last One Hundred Years" written by Dr. Wilmar M. Allen, former director of Hartford Hospital, and on "Looking Ahead One Hundred Years" by the present director, Dr. T. Stewart Hamilton. Following these, Francis W. Hatch of the Board of Directors at the Massachusetts General Hospital entertained the assembly with bits of humor and wisdom, purporting to emphasize the importance of cooperation between the lay board of directors and the medical staff in any community hospital.

With the House of Delegates meeting on Tuesday and the scientific sessions following on Wednesday and Thursday, altogether the week was a busy one for many.

### Hospital Care of Poliomyelitis

The medical profession has apparently reoriented itself in the treatment of poliomyelitis and its attitude toward the best methods of handling a disease for which no "medical magic" has been developed. Sister Kenny's contribution to treatment in many instances made the patient more comfortable while his biological defenses were trying to reduce to a minimum the final physical damage he was to inherit from the infection. Physicians, nurses and physical therapists trained in the Kenny method of diagnosis and treatment appeared in considerable numbers throughout the country. It was not long before there



was talk of "pure Kenny" and "modified Kenny" methods. The "pure Kenny" led to some rather unusual recommendations such as keeping children out of school for a whole year regardless of whether the patient came out of the acute phase with no demonstrable paralysis or with considerable involvement. This certainly represented an extreme. As a further result of the Kenny stimulation there was a groundswell to set up centers for the treatment of poliomyelitis. Wherever there were isolation hospitals, the recognized cases were hospitalized there. In many instances patients in the acute stage of the disease—the "viremic phase"—were transported great distances to be admitted to such centers on the premise that some special treatment could be found there which was not obtainable in the community hospital.

We are now swinging back to a middle of the road approach to the acute case of polio; we are mindful of the fact that a patient in the acute phase has an active infective process with the virus being circulated throughout the body bathing the anterior horn cells, and other nervous tissues—the sensitive target tissues of the disease. It has been frequently pointed out that a patient has his best chance of avoiding extensive central nervous system involvement if he is kept quiet during this period, with as little physical motion as possible. During this stage of the disease devoted nursing care comes as close to the necessary "medical magic" as we can expect in our present state of knowledge.

Because of these developments it is logical that an increasing number of physicians are not rushing every patient during the polio season to a polio center for a spinal puncture if he displays any of the early symptoms of the disease. Many today feel that it is better medical care to keep the patient at home and under frequent observation.

The development of the "polio center" concept brought about some other professional and lay attitudes. The layman thought of it as a horrid disease because it had to be treated in such a special way—in such a special facility. The doctor and nurse shut out from acquaintance with the hospital care of such patients developed a feeling of inadequacy since apparently only highly trained personnel operating in "polio centers" could treat and care for these patients. Then too, unnatural fear of the disease appeared. Its degree of communicability was distorted out of all proportion to the facts. Married nurses

refused to care for polio patients lest they carry home the virus on their persons or clothing. (It took years for researchers to learn how to keep the virus alive and grow it outside the human body.)

Much of this is undergoing change. In 1948 the American Medical Association Directory of Hospitals indicated that 21 isolation hospitals had disappeared from the scene within the previous 17 year period. The 1953 directory indicated that 34 more had been closed during the five years from 1948 to 1953. Today there are only 31 such institutions listed in the United States, located in only 15 of the states of the Union—all east of the Mississippi River where the concept of the "colonial pest house" has been part of the tradition of the people.

In Connecticut there is an increasing number of general hospitals which feel that "polio" should be cared for like any other disease in the community. Grace-New Haven Hospital, Norwalk Hospital, Waterbury Hospital, Bridgeport Hospital, Stamford Hospital, St. Mary's Hospital, Waterbury, Danbury Hospital, Backus Hospital, Norwich, Greenwich Hospital, Sharon Hospital have been admitting cases of polio as a matter of policy and not by accident.

As we go to press several general hospitals in Hartford County are also contemplating opening their doors to patients with poliomyelitis and other communicable diseases.

### Changing Techniques in Preventive Medicine

The techniques employed in preventive medicine may be either communal or individual and strangely enough, the latter are the older. There is no doubt that the Chinese were acquainted with inoculation as a restraining factor in the spread of epidemics of smallpox hundreds of years ago though Garrison thought that they probably got this knowledge from the East Indians. Inoculation was quite extensively used even in this country before Jenner put farmer Jesty's preventive cowpox inoculation on the map, a great improvement on inoculation which sometimes resulted in fatal attacks of smallpox.

It is difficult for citizens of civilized countries, especially city dwellers, to imagine the unhygienic conditions which prevailed, even in some very large cities, two or three centuries ago. In London, for example, before the epidemic of plague in 1665 and the succeeding great fire in 1666, the streets were

narrow, houses had overhanging second stories which shut out much sunlight, there was no domestic running water, and the sewage ran freely in the open gutters along the curbs. No wonder this era was described as the "age of smells" as contrasted with the existing "age of noise." When London was rebuilt after the great fire, overhang of the second stories of houses was banned, sewers were constructed, and running water was installed in many houses. However, long after this not all large cities had an impeccable water supply. In Albany, New York, for example, as late as 1897 the drinking water was taken unfiltered from the Hudson River only 5 miles below Troy. As one Rabelaisian critic remarked: "The Inhabitants of Albany can always tell when the asparagus season begins in Troy." However, the great accomplishments of communal hygiene, still by no means universally prevalent, were pure water and food, adequate disposal of sewage, and sanitary housing conditions.

With the advent of Bacteriology and Immunology at the end of the nineteenth and the beginning of the twentieth century new preventive factors came into operation. The restriction of some parasitic diseases was solved by attacking their insect vectors or by producing artificial immunity by the inoculation of vaccines or sera. While there are still some common infections, notably those of viral origin, the prevention of which is unsolved or only partly solved, there are others such as typhoid fever, smallpox, diphtheria and tetanus, which a modern medical student rarely sees. Aseptic techniques too have practically wiped out the former septic horrors of surgery and obstetrics.

Perhaps the most disappointing of proposed individual preventive measures has been the periodic examination of supposedly healthy adults. In babyhood and early childhood special clinics have been created to care for the offspring of the indigent and alert pediatricians have adopted the successful preventive techniques and often apply them for a fixed annual fee to the children of parents able to pay. In adults the situation is different, for it seems difficult to persuade many of them to submit to periodic check-ups when they feel well. Even some doctors seem to regard such examinations as uninteresting, though organizations exist which do such work for an annual fee and some life insurance companies furnish such surveys to their policy holders gratis.

In recent years possible solutions, or at least partial

ones, to this problem have appeared, namely, special clinics such as those for industrial workers, and for tuberculosis, circulatory disease and cancer have been set up and screening processes of groups of people for specific diseases have been used. For some reason the specific seems to appeal to the popular imagination where the general fails to appeal. The free screening of thousands of people for pulmonary tuberculosis in Los Angeles County and other places has given highly informative and valuable results, and the more recent screening of volunteers for diabetes mellitus conducted at the Illinois State Fair showed 263 positive out of 1,673 examinations.\* Obviously this method can be applied to other diseases and should be, notably because many chronic diseases are symptomatically silent. Even these methods are not 100 per cent perfect, not merely because human judgment may err but also because some latent diseases cannot be detected by physical examination even with the help of technical tests. None the less it cannot be denied that great progress has been made in the past half century and that more can be hoped for in the future.

G. B.

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\*Gowen, Illinois State Medical Journal, Nov. 1953.

### Future Liability for Military Service

The Connecticut State Advisory Committee to Selective Service, which is operated by the Society, has been informed that the requirements of the military services for physicians between July 1, 1954 and June 30, 1955 are such that all who have obligations for military service in Priority I and Priority II and that portion of Priority III born after August 30, 1922, will, in all probability, be called to duty.

Due to new processing regulations it will take much longer to issue commissions after applications are filed than in recent months. Therefore, every effort should be made to have those physicians who will finish internships and residencies by July 1 apply at once for commissions so there will not be a protracted period of waiting between the end of the hospital year and the call to active duty. The only exceptions to the above are those cases of individual physicians who occupy positions that have been declared essential in medical practice in remote communities or those physicians who hold essential positions on medical faculties.



## Family Incomes in Connecticut

People in Connecticut, on the average, have more money to spend or save than in any other part of the United States. In the survey of family incomes in the United States made annually by *Sales Management* magazine, it is shown that in 1953 the average American family had \$5,173 to spend after paying income taxes. In some states the family income was far above the national figure. Connecticut led the nation with an average spendable family income of \$6,730. Mississippi was lowest with \$3,154. The District of Columbia was second after Connecticut, \$6,544, then New Jersey, \$6,065, Wyoming, \$5,878 and Illinois, \$5,862.

The survey also gave figures for 233 metropolitan retail areas within the states and again Connecticut communities led. The Bridgeport-Stamford-Norwalk area had the highest family income average for the country, next came Washington, D. C., then the Hartford-New Britain area. Although medical care is not exactly a commodity to be purchased like food or clothing, it is purchasable and costs a price. These figures of high family income have a profound effect upon medical practice in this State.

## Expenditures for Health in Connecticut

Wide variations in the 1952 per capita expenditures for public health from tax funds in the towns and cities of Connecticut have come to light from figures released by the State Department of Health. The all time low for any town in the State during 1952 was \$0.04 per capita spent by Hartland while the all time high for the same year was \$2.87 expended by Greenwich.

One might postulate that Hartland is a small town, possibly very healthy, but in that same population group of 1,000 or less we find that the little town of Union expended \$2.11 per capita in the interest of public health. Other towns which apparently found little use for such expenditures were Burlington and Chester each with \$0.07 per capita expended. The variation in tax funds expended for public health protection is in direct proportion to the actual amount of services provided in the communities.

A look at the large cities of Connecticut shows less variation. The range was from a low of \$1.10 in Waterbury to \$2.16 in Hartford, the other five cities being spread well over the intervening range.

It is a bit difficult to explain how any town can do justice to its inhabitants healthwise on an expendi-

ture of a few cents per capita. It may be that private enterprise, that valuable Yankee characteristic, makes it unnecessary to dip into tax funds to supply public health needs. Or might it not be true that Greenwich with its \$2.87, Westbrook with \$2.80, Orange with \$2.57, Old Saybrook with \$2.52, Hartford with \$2.16, North Branford with \$2.02 and Weston with \$2 per capita expended are really doing a much better job? Where there are such wide variations we suspect there must be a better product to justify the the expense.

## Mortality Figures

At the recent meeting of the Society of Actuaries some interesting figures relating to mortality statistics were presented. The Prudential Insurance Company, after studying 88,000 claims, found that women life insurance policyholders experience a mortality one-third less than that for men. For the age group 10 to 25 the female mortality was 50 per cent less than for men, between 30 and 34 years it was 17 per cent less, and from 60 to 64 it was about 42 per cent less. It was also found by this study that women keep their policies in force at a much higher rate than men.

This same Society of Actuaries made a Medical Impairment Study and came up with the discovery that the mortality among persons with physical impairments has decreased in the aggregate in about the same proportion as that among standard risks during the past 15 years. Even though substandard insurance is on the increase there may be an increase in the number of risks previously declined and now accepted at a lower extra premium rate due to the spectacular advances in medicine and public health.

It was reported that in the current study, favorable mortality was shown by persons who had had pulmonary tuberculosis, by women who had reported female diseases and conditions, and by persons who had suffered nervous breakdown or who were psychoneurotic. A history of migraine headaches or of cerebral concussion without residual damage did not indicate that higher than average mortality might be expected.

One of the important findings of the study was that persons who had reported two or more deaths under age 60 in their immediate families from heart or vascular conditions showed a death rate considerably above average. Policyholders who had been operated on for gastric or duodenal ulcers showed higher mortality than similar cases in the last study made.

## PROGRESS IN CLINICAL MEDICINE

### PRECIPITATE LABOR

EMIL D. KARLOVSKY, M.D., and HERBERT THOMS, M.D., *New Haven*

THE records show that approximately 12 to 13 mothers out of every 100 delivered at the Grace-New Haven Community Hospital, University Service from 1949 until July 1951 had labors of three hours or less. Because of this incidence it becomes important to consider the possible causes, dangers, disadvantages or advantages of short and precipitate labor.

The definition of a precipitate labor is usually given as a labor which lasts from its onset until completion in three hours or less. It is important to distinguish between true and apparent precipitate labor. A true precipitate labor conforms to the above definition. An apparent precipitate labor on the other hand may appear to be three hours or less in duration, while actually it is longer. This happens whenever the early labor contractions, because of their mildness and/or painlessness are overlooked; the time of onset of labor being somewhat obscured. It is important to differentiate precipitate labor from precipitate delivery. A precipitate delivery is a rapid and usually unexpected culmination of labor of any length, the delivery being not anticipated is on this account often unattended.

This paper is a survey of 270 mothers whose labors were three hours or less in duration. Two hundred were multigravidas and 70 were primigravidas.

The incidence of precipitate labor is variably reported from five to nine per cent. We found the incidence to be 12.9 per cent in 1,000 unselected deliveries. Also we found that a precipitate labor is eight times more frequent in the multigravida than in the primigravida. One can only speculate as to some of the factors which may have influence in precipitate labor. It is conceivable that mothers prepared for childbirth in a training program are more likely to have a precipitate and in general a shorter

labor. A prepared patient usually builds up certain emotional defences, has less tension and is able to tolerate pain to a better extent. Also, a prepared patient usually requires less anesthesia or analgesia, either of which can be responsible for prolongation of labor, particularly if used prematurely or in excessive amounts.

The causes for a precipitate labor are obviously numerous. In multigravidas diminished resistance of the cervix and soft parts accounts in many instances for precipitate labor. This is occasionally seen in the primigravida, the first stage proceeding rapidly and only the soft tissues of the pelvis exerting a delaying resistance in the second stage. In many instances artificial rupture of membranes or prematurely ruptured membranes in individuals with diminished cervical resistance seem to have a tendency to shorten labor both in primigravidas and multigravidas.

The size of the pelvis and the size of the infant may effect the duration of labor. The contracted pelvis has long been associated with prolonged labor. In this series the incidence of a borderline contraction of the pelvis in primigravidas who had precipitate labor was less frequent than for the other primigravidas. However, this was not true of the multigravidas as the incidence of such pelvises was the same.

Eight per cent of multigravidas in these 1,000 deliveries had an infant of 4,000 Gm. or over, however, only 2.5 per cent of multigravidas with precipitate labor had infants in this group. The same ratio was found true for the primigravidas. Three per cent of all primigravidas were found to have an infant of 4,000 Gm. or over, but only 1.1 per cent of the precipitate labor group had an infant of that size. The incidence of small infants, 2,500 Gm. or less, born to multigravidas was found not to have any specific relation to the length of labor. However, 12 per cent of primigravidas with a precipitate



labor had infants of 2,500 Gm. or less as compared to an eight per cent incidence of such infants in all other primigravidas. This would indicate that in the primigravida the size of infant does have some association with precipitate labor.

In this group of precipitate labors approximately 20 per cent seemed to be the result of abnormally strong and frequent contractions. In such labors dangers to both the mother and child are inherent. Tumultuous uterine contractions with but short intervals of relaxation can impair oxygenation of the infant. To this may be added the descent of the infant through the pelvis with the danger of cerebral injury. Analgesics even in average doses not only may not improve such a situation, but on the contrary may be deleterious in their depressant action if the birth takes place within an hour after administration. Larger doses of analgesics or of inhalation anesthesia may slow down too rapid progress, but even here caution is necessary. Unless one has had a wide clinical experience it would seem wise to withhold such medication and institute the continuous inhalation of oxygen.

In well selected cases, chiefly in multigravidas, medical induction of labor and artificial rupture of membranes will result in precipitate labor in some 15 to 20 per cent of instances. An interesting finding was that twice as many primigravidas in the precipitate group when compared to those with longer labors had some grade of pregnancy toxemia. This was not true in the multiparous group.

In considering the incidence of laceration we found there were less first and second degree lacerations and/or extension of episiotomy than in those with longer labors. In this group there were no third degree lacerations or other extensive soft part trauma. None of the 70 primigravidas had a postpartum hemorrhage. The incidence in the 200 multigravidas was essentially the same as in the larger group.

There was no puerperal morbidity in the group of primigravidas and in the multigravidas no significant difference between them and the larger group.

Four of the multigravidas had forceps delivery. In two the indication was fetal distress. Eight primigravidas had forceps deliveries and in six the indication was fetal distress. In ten other instances fetal distress was noted at some time during the labor. All of these infants were delivered in good condition with no apparent sequelae. We are under the im-

pression that symptoms of fetal distress may be of higher incidence in mothers with precipitate labor.

In this series there were three fetal deaths, none of which can be directly attributed to the shortness of labor. One was a 1,500 Gm. premature infant that died 12 hours after a breech extraction performed under pudendal block anesthesia. This was the third similar episode for this unfortunate mother who previously lost all three infants neonatally after a premature labor. The second was a 2,428 Gm. infant that had severe erythroblastosis. The third was a 1,500 Gm. infant that died five minutes after a spontaneous delivery. The mother was an unregistered woman with positive serology. Autopsy was denied. There was one more death not included. This occurred five weeks after delivery. The infant weighed 1,945 Gm. at birth. The cause of death remains undetermined. There were no cases of suspected cerebral trauma. There were no unattended deliveries.

In this series of 270 deliveries the use of analgesia and/or anesthesia was less than in the group with longer labors. Twenty per cent of multigravidas had no anesthesia, but had analgesia. Twenty per cent had no analgesia, but had anesthesia. Twenty-five per cent had neither analgesia or anesthesia and the remaining 35 per cent had both. Twice as many multigravid mothers delivered without analgesia or anesthesia than those with longer labors.

Twenty-two per cent of primigravidas had no anesthesia and had analgesia, and eight per cent had anesthesia and no analgesia. Thirty-four per cent of primigravidas delivered without either analgesia or anesthesia. In the entire group 36 per cent had both analgesia and anesthesia.

#### DISCUSSION

The contributory factors leading to a precipitate labor are: Large pelvis, small infant, strong and frequent uterine contractions, absence of pain and tension, diminished resistance of the cervix and soft parts, and ruptured membranes. Any combination of three of these factors will increase the likelihood of a short or a precipitate labor. Certain of these factors may be considered as static: the size of the pelvis and the infant, the lessened resistance of the cervix and soft parts. Uterine contractions, pain and tension, however, are subject to control and membranes can be ruptured in selected cases.

In this series it appears that as far as the mother is concerned a precipitate labor has no disadvantages,

save for the occasional uncomfortable or painful labor. For the majority of mothers this type of labor seems to be ideal. However, the precipitate labor in about 20 per cent is the result of severe and frequent uterine contractions and impairment of fetal circulation is an ever present danger. A particularly poor combination is a precipitate labor due to overactivity of the uterus and the presence of a premature infant. If a precipitate labor is culminated by a precipitate delivery there is an increased incidence of perineal and vaginal lacerations. If delivery is unattended there would be theoretically an increase in puerperal infection. Cerebral trauma may result from a too rapid descent of the infant through the pelvis. In an unattended delivery the infant may be deprived of proper care.

We believe that mothers should be seen early in labor. This is particularly true in mothers who have had the training for childbirth experience and who may discount early uterine contractions and pay no attention to them. With us mothers can be admitted to the hospital for a four hour period during which they are observed. If she is not in labor the patient may return to her home and the hospital makes no charge for this admission. Once a patient is admitted in labor it is the admitting physician's responsibility to stay with the mother for 20 to 30 minutes timing the contractions and checking the fetal heart. If there is any reason to suspect that the labor will progress rapidly, constant attendance by a physician or nurse is imperative. Only in this way can early evidence of fetal distress be detected. The selection and correct timing of analgesia and anesthesia will improve the safety of both mother and child. Continuous inhalation of oxygen can be started whenever the need arises. Precipitate labor in the majority of cases, if well supervised and intelligently conducted, is an ideal labor for the mother and without increased danger for the infant.

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### Effect of Atomic Radiation on Pregnancy

Radiation from the atomic bomb explosion over Nagasaki, Japan, in 1945 had considerable effect on the outcome of pregnancies of women in the city who were pregnant at the time.

Among 30 pregnant women with major signs of radiation injury, there were three miscarriages, four stillbirths, three babies who died within the first month of life, three infants who died within the first year of life, and one who died at two and one-half

years. Four of the surviving 16 children were mentally retarded.

Drs. James N. Yamazaki, Stanley W. Wright and Phyllis M. Wright, Los Angeles, found this evidence in a study of pregnant women exposed to the atomic blast at Nagasaki and their offspring. Their report appears in the *American Journal of Diseases of Children*, published by the American Medical Association.

The pregnant women studied were divided into two groups—98 who were within the radiation area, 30 of whom showed what the physicians termed major radiation injury signs, and a control group of 113 pregnant women who were outside the radiation area of the city at the time of the bombing.

The over-all morbidity and mortality of the outcome of pregnancy among the 30 women who suffered major radiation injury signs was approximately 60 per cent, as compared to 10 per cent among the 68 other pregnant women within the radiation area, and about six per cent among the 113 women outside the radiation area, the doctors stated.

In the group of 68 women who were within the radiation area but sustained no major signs of radiation injury, there was one miscarriage, two stillbirths, three babies who died within the first month of life, and one case of mental retardation.

In the control group of 113 pregnant women outside the radiation area, there were two miscarriages, one stillbirth, one baby who died within the first month of life, and three infants who died within the first year of life.

In addition, the study disclosed that children born to mothers with major signs of radiation injury were retarded in growth and development, the doctors stated. These children were significantly smaller in height and head circumference than those children born to mothers in the control group.

"It is difficult to evaluate the effect of radiation on this mortality and morbidity, since other factors, such as trauma, burns, infections, etc., may have a deleterious effect on the fetus," the doctors stated. "The evidence strongly suggests, however, that radiation, either directly to the fetus or indirectly as a result of its effect on the maternal tissues, was of considerable importance in determining the outcome of these pregnancies."

The physicians are associated with the Laboratories of the Atomic Bomb Casualty Commission, Hiroshima, Japan, and the Department of Pediatrics, University of California Medical Center.



## THE PRESIDENT'S PAGE

### DOCTORS AND SOCIAL SECURITY

Doctors of great wealth, and those who have no interest in establishing funds for their own retirement or (in case of their death) for the support of wives and dependent children, need waste no time on this article. It is directed to those of modest or moderate means who do have an interest in the above objectives.

In last month's issue of this Journal there appeared an admirable article by Attorney David M. Richman, entitled: "Social Security: Present Attempts to Include the Self-Employed Professionals." This was but part of a lucid and convincing discussion of the subject by Mr. Richman a month earlier before a joint meeting of several committees of the State Bar Association, the State Dental Association, and our Society. It was because of the enthusiasm of the physicians in that audience that he was asked to permit publication of part of his talk in the Journal. And it is through his kindness and deep interest that I am now privileged to present more of the facts relating to this issue, which is of far greater importance to physicians than most of them realize. It is my hope that all who have not read Mr. Richman's article will do so before proceeding with this supplement, which consists largely of material that he graciously supplied.

The inclusion of self-employed professionals in the Social Security system would cost 500,000 doctors, dentists, lawyers, accountants, engineers and other professional groups in the United States 63 million dollars a year at the present rate of 3 per cent on the first \$4,200 of income, if the Reed Bill (HR7199) is enacted. This huge tax payment would be increased steadily over the next fifteen years to nearly 100 million dollars annually, because the rates rise each five years until they reach 5¼ per cent in 1970. In Connecticut, it would mean \$1,134,000 in Social Security tax payments each year for self-employed professionals. Every such person would pay \$126 per year at the present rates, with increases scheduled annually for the next 16 years, up to \$220.50 per year, providing the \$4,200 base is maintained. It is evident that this will not remain constant, since it has already been increased from \$3,000 to \$3,600, and the Reed Bill provides for a further increase to \$4,200. It is quite likely that the base will be raised during the next 16 years to \$6,000 or more. Even if the base remains at \$4,200 and the tax rate is not increased beyond the 5¼ per cent now scheduled for 1970 and thereafter, a physician entering this system at the age of 30 years and continuing until his retirement at age 65 would have paid a total of more than \$6,800.

What does he receive in return for this investment? Upon attaining the age of 65 years he would receive an average of \$52 to \$62 per month, provided he was then earning not more than \$1,000 per year. At the present time 50 million people are contributing to the Social Security Fund, and more than 5 million have reached the age of 65. But only 2 million of these can live on their Social Security monthly checks which, in December 1953, averaged \$52! The other 3 million wage earners who have been contributing to the Social Security Fund for many years have been forced to re-enter the labor market in order to live decently. They must wait until they are 75 years of age in order to enjoy the so-called "benefits" of their Social Security payments.

The proponents of the Social Security Act never contemplated that the self-employed professionals should be included in the system; it was designed to cover only those whose income is in the form of wages or salaries from employers. The original Act and all later amendments have specifically excluded self-employed professionals. Many such professional workers are at the height of their earning power at the age of 65, and are not willing to abandon a fascinating and rewarding activity in order to qualify for the pitifully meager Social Security payments. The average retirement age for doctors is said to be 74 years.

A far more equitable plan is now pending in Congress, the Jenkins-Keogh bill. If enacted into law it will enable the self-employed professional to deduct each year a limited amount of "earned income" and apply this toward a "Restricted Retirement Fund" or toward the purchase of a "Restricted Retirement Annuity Contract." He will be able to deduct annually up to \$7,500 or 10 per cent of earned income, whichever is less, but not more than a total of \$150,000 during his lifetime. As stated before a Congressional committee, this bill "would give the 11 million self-employed people who want to save for their old age an opportunity to do so under conditions approximately equal to those provided by corporate pension plans approved by the Bureau of Internal Revenue."

The American Medical Association, the American Dental Association, and the Connecticut State Bar Association are strongly opposed to the compulsory inclusion of their members in the Social Security system, as provided by the Reed bill, and are in favor of enactment of the Jenkins-Keogh bill. It is my personal belief that every physician who knows the facts will cordially endorse that official stand. If so, it is not too late to make your views known to your Congressmen and Senators.

To Mr. Richman, my co-author and silent partner, I extend heartfelt thanks for his careful studies and generous helpfulness.

H. M. Marvin, M.D.

Since this President's Page was written, there have been rapid developments in Congress. As this issue goes to press, the House Ways and Means Committee has voted to exclude physicians from the Social Security plan.

# THE SECRETARY'S OFFICE

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## ANNUAL MEETING OF THE COUNCIL

The 1954 Annual Meeting of the Council was called to order by the Chairman, Dr. Danaher, at 4:30 P. M. on Thursday, May 13, at the offices of the Society in New Haven. There were present in addition to Dr. Danaher, Drs. Marvin, Stringfield, Couch, Barker, Murdock, Gibson, Feeney, Gallivan, Tracy, Russell, Labensky, Ottenheimer, Gens, Clarke, Walker, Dwyer, Gilman. Absent: Drs. Weld, Gildersleeve, Fincke, Ursone, Flaherty, Buckley, Archambault.

The Chairman introduced new members of the Council and changes. Dr. Marvin succeeds Dr. Gildersleeve as President. Dr. Oliver L. Stringfield becomes President-Elect. Dr. Gildersleeve succeeds Dr. Whalen as Councilor-at-Large. Dr. Ursone succeeds Dr. Walker as Councilor from Litchfield County. Dr. Walter I. Russell succeeds Dr. Gettings as Councilor from New Haven County. Dr. Harold M. Clarke succeeds Dr. Ogden as Alternate Councilor from Hartford County. Dr. Walker succeeds Dr. Ursone as Alternate Councilor from Litchfield County. Dr. Christopher E. Dwyer succeeds Dr. Otis as Alternate Councilor from New Haven County.

### DR. DANAHER REELECTED

The president assumed the chair to receive nominations for Chairman of the Council for the year 1954-1955. Dr. Danaher was nominated and reelected unanimously.

### FAIRFIELD COUNTY 1955

An invitation from the Fairfield County Medical Association was presented for the Society to hold its 1955 Annual Meeting at Stratford. The invitation was accepted with appreciation.

### EXAMINERS OF HYPERTRICHOLOGISTS

The terms of service of Reginald F. Gillson, New Haven and Michael J. Morrissey, Hartford, as members of the State Board of Examiners of Hypertrichologists expire on June 30, 1954 and Section 1761c of the General Statutes of Connecticut provide that physician members of this Board shall be nominated by the Council of the State Medical Society. The remaining members of the Board have asked that Dr. Gillson be renominated and they would also like to have Dr. Morrissey renominated, but he has declined to serve again. Dr. Gillson was renominated and Dr. Ellwood C. Weise, Sr., Bridgeport, was also approved for nomination.

### COMMITTEE ON BY-LAW CHANGES

Dr. Danaher appointed a Subcommittee to Review and Recommend Changes in the By-Laws and Charter relating to the status of Alternate Councilors, the Speaker and Vice-Speaker of the House of Delegates as members of the Council, Chairman, F. Erwin Tracy, C. Louis Fincke and Walter I. Russell.

### COMMITTEE ON STAFF RETIREMENT PLAN

The Chairman, Dr. Danaher, referring to an item in his Annual Report to the House of Delegates on April 27, concerning appointment of a Subcommittee to Inquire into the Establishment of a Retirement Plan for Staff Members, asked that the following committee be approved for this purpose. Chairman John N. Gallivan, Cole B. Gibson and Edward J. Ottenheimer.

### COMMITTEE ON CRASH INJURY RESEARCH

It was voted to add Brae Rafferty, Willimantic to the Society's Advisory Committee to the Cornell Crash Injury Research.

### ADVISORY COMMITTEE TO STATE WELFARE DEPARTMENT

It was voted that Dr. J. Harold Root, Waterbury, a pediatrician, be appointed to the Society's Advisory Committee to the State Welfare Department.



## FEDERAL GRANTS

The answers prepared by the Society's Committee on Public Health, to the questionnaire on Federal Grants, that had been received from the Commission on Intergovernmental Relations (See AMB 1/14/54 "C"), were presented and approved and the secretary was directed to forward them to Griffenhagen Associates, New York City, which organization had been engaged in making the inquiry in Connecticut for the Intergovernmental Commission.

## INTERN TRAINING

The opinion of the Committee on Medical Education and Licensure concerning intern training and recruitment which had been requested from the Society by the American Medical Association (see AMB 4/7/54 "C") was presented and with some revision adopted as follows to be forwarded to George Klump, chairman of the Ad Hoc Committee on Internships of the American Medical Association.

1. It is alleged that teaching hospitals have increased the number of available internships and residencies since the "matching plan" went into effect, and it should be urged that such hospitals discontinue this policy. If this allegation is correct, it has had the effect of limiting the number of interns available for smaller hospitals which thereupon scour the country and the world for any available interns to fill their requirements without regard to their training or capabilities. This obviously defeats the purpose of the teaching institutions which are trying to improve the quality of medical education.

2. It is believed that a rotating internship for the first year after graduation is highly desirable and all specialty boards should be urged to require such a year of rotating internship prior to entering upon a program of specialized training.

## SUMMER PLANS

Plans for Council activity during the summer were discussed at length. The impropriety of having a summer Executive Committee, which is not in any way authorized in the By-laws, was presented by Dr. Gallivan. It was concluded that there would be no Executive Committee appointed and whenever necessary for Council action on business, if it could not be concluded by postal vote from the members of the Council, the Chairman was given the authority to call a meeting.

Dr. Ottenheimer generously invited the Council to meet at his farm in Windham during the summer and his invitation was accepted unanimously. It was

agreed that the Council would meet in Windham in July, on a date to be determined by the Chairman, Dr. Ottenheimer and the secretary, and at that time any cumulative business could be discharged.

## New Members

## FAIRFIELD COUNTY

Edith M. Beck, Greenwich  
 Alexander Bellwin, Stamford  
 Leo H. Berman, Norwalk  
 Edward S. Breakell, Stamford  
 Spencer F. Brown, Darien  
 Frank C. Bucknam, Newtown  
 Richard E. Caron, Fairfield  
 George W. Changus, Danbury  
 Gregory K. Dwyer, South Norwalk  
 Howard K. Ente, Westport  
 Robert H. Freedman, Stamford  
 Gail A. Gaines, Newtown  
 Jerry Goldfarb, Stamford  
 Walter I. Gryce, Danbury  
 Charles K. Hamilott, Danbury  
 Victor A. Machcinski Brooklyn, N. Y.  
 Donald H. Millard, Stamford  
 Albert M. Moss, Newtown  
 Paul D. Murphy, Bridgeport  
 Robert H. Noonan, Bridgeport  
 Walter J. Richar, Stamford  
 Arthur W. Samuelson, Bridgeport  
 Joseph J. Sciarillo, Bridgeport  
 Franklin H. Streitfeld, Westport  
 Jerrold vonWedel, Cos Cob  
 Roy G. Wiggans, Jr., Norwalk  
 William F. Zehl, Glenbrook  
 Richard A. Zucker, Wilton

## LITCHFIELD COUNTY

Llewelyn E. Liberman, Torrington

## WINDHAM COUNTY

Lloyd H. Davis, Storrs

## STUDENT MEMBERS ELECTED

Maureen Archambault, Taftville  
 Tufts Medical College—Class of 1957  
 Pre-Med: Tufts College  
 Parent: Henry A. Archambault, M.D.

Timothy F. Brewer, III, West Hartford  
 New York Medical College—Class of 1957  
 Pre-Med: Yale University  
 Parent: Timothy F. Brewer, M.D.

Guy A. Settipane, Middletown  
 New York Medical College—Class of 1957  
 Pre-Med: Brown University  
 Parent: Joseph Settipane

The meeting adjourned at 6:30 P. M.

### Meetings Held in May

- May 4—Committee on Medical Care of Veterans
- May 5—Fellowship Award Committee of Connecticut Cancer Society
- May 6—Coordinating Committee, State Blood Bank  
           Committee on Public Health  
           Committee on School Health
- May 11—Board of Directors, Connecticut Medical Service
- May 12—Committee on Neonatal Mortality  
           Connecticut Medical Examining Board
- May 13—Council, Annual Meeting
- May 19—Committee on Maternal Mortality and Morbidity
- May 20—Medical Advisory Committee, Connecticut Cancer Society  
           Medical Advisory Committee, Crash Injury Research
- May 26—Committee on Industrial Health  
           Connecticut Health League

### Fifty Year Awards to Four Physicians

Four physicians who have completed 50 years of active membership in the Connecticut State Medical Society were honored at a special ceremony during the Society's annual dinner in Hartford on April 28.

The physicians are Harold S. Backus and William H. Van Strander, Hartford; Orin R. Witter, West Hartford; and Robert J. Lynch, Bridgeport.

Specially designed service pins were presented to the four new fifty year members by George H. Gildersleeve, Norwich, president of the Society.

The new awards bring to 31 the number of the Society's fifty year members. John C. Lynch, Bridgeport, is senior member of the group. He has held membership in the Society since 1887. Charles J. Foote, New Haven, second ranking member, joined the Society in 1888.

Two women physicians are members of the group, Jessie W. Fisher, Middletown, and Laura H. Hills, formerly of Willimantic and now a resident of Winter Haven, Florida.

### New Haven VNA Honors Dr. Winslow

At a dinner in celebration of its Golden Anniversary, the New Haven Visiting Nurse Association announced the gift of a fund to establish an "Anniversary Day" in the name of Dr. and Mrs. Winslow. The income from this fund is used for services rendered by a nurse on one specific day each year.

The gift is a singularly appropriate recognition of an inspiring collaboration which began at M.I.T. when Mr. Charles Winslow published papers on bacteriology jointly with a charming student, Anne F. Rogers. Shortly, the joint authorship changed to "Winslow and Winslow."

The intervening years have deepened and broadened the Winslows' mutual interest in all aspects of public health and their name is internationally, as well as nationally, associated with health activities.

Mrs. Winslow, a former President of the VNA, is chairman of the Regional Committee of the Board Members' Organization of Connecticut Public Health Nursing Agencies. Dr. Winslow, since his retirement as chairman of the Yale Public Health Department, continues as editor of the *American Journal of Public Health*, chairman of the New Haven Housing Authority, Honorary Vice-President of the Connecticut Planned Parenthood League, and honorary chairman of the Board of the Federation. The bibliography of his writings runs to more than 500 titles. Among his citations are the Lasker, the Sedgwick and the Shattuck awards, and the Leon Bernard Medal.

### Dr. Hiscock Thrice Honored

Dr. Ira V. Hiscock, professor of public health at Yale University School of Medicine, has received the 1954 Shattuck Award for outstanding and meritorious contributions to the field of public health. This award was established by the Massachusetts Public Health Association in 1950. Dr. Hiscock has also received the 1954 Medal of the Connecticut Division of the American Cancer Society. Dr. Hiscock was recently elected president of the Association of Schools of Public Health of the United States and Canada.



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## CLINICAL PATHOLOGICAL CONFERENCE

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CHRISTIE E. McLEOD, M.D., and JEROME O. KIRSCHBAUM, M.D., *Middletown*

### CLINICAL SUMMARY

A 57 year old, white male was admitted to the hospital because of severe abdominal pain and a shock-like state. The onset of the illness was characterized by nausea which made the patient afraid to eat. This condition existed for approximately two weeks during which time his diet consisted mostly of milk. On the day before admission he had eaten solid food. On the morning of admission he vomited twice. This was followed by severe abdominal pain which was most intense beneath the tip of the sternum and was aggravated by breathing. His wife noted that he was cold and gray at that time.

In 1916 the patient had jaundice. In 1942, 9 years before admission, there was x-ray evidence of a peptic ulcer. The patient had been on an ulcer regime since that time though he did not follow his diet very closely. In 1950 he had an attack of sour stomach with nausea, vomiting, and some hematemesis. That attack was of two to three weeks' duration. He has frequently complained of pain coming on before meals, relieved by food and alkalis. The bowels have been regular and there has been no weight loss. The patient stated that he had had sinus trouble for many years. The history also indicated that he had had shortness of breath and palpitation on exertion; the duration of these symptoms is not stated.

Physical examination revealed a patient who appeared acutely ill and in severe pain. He was not sweating but the extremities were cold, the pulse was rapid and of poor quality. The heart sounds were faint and the rate rapid with occasional extra systoles. The chest expansion was poor (because of pain), rales were present at the left base. There was generalized abdominal rigidity and tenderness most intense in the left upper quadrant. Rectal examination was negative. Varicosities were present in both legs. The temperature was 98° and the pulse 90.

Respirations 28. The blood pressure was 125 systolic and 70 diastolic.

Examination of the blood showed an erythrocyte count of 5 million, hemoglobin 15.4 gms., leukocytes 13,900 with 90 per cent neutrophils, 15 per cent of which were stab forms, 8 per cent lymphocytes and 2 per cent mononuclears. Urinalysis was negative for albumin and sugar. The specific gravity was 1.010. A flat plate of the abdomen taken after a Levine tube had been passed showed no free air under the diaphragm, no dilated small intestinal loops, considerable gas and fecal material scattered throughout the large bowel. The Levine tube was coiled on itself in the stomach.

A laparotomy was done about two hours after admission and showed the omentum to be adherent to a puckered area on the anterior surface of the duodenum. There was no free fluid. Following the operation the BP was 145 systolic, 85 diastolic, pulse 100 and of better volume. The heart sounds were still distant. An electrocardiogram showed elevation of the ST segment in lead III with symmetrical inversion of the T<sub>3</sub>. Rales were present at the left base where there was tympanic note with moderate suppression of breath sounds. Leg measurements at 10 cm. intervals above the ankles showed R. 25 cm. L. 27 cm., R. 35 cm., L. 37 cm., R. 33 cm., L. 35.5 cm., R. 38 cm., L. 38 cm.

The first postoperative day the temperature was 100°-103°, the pulse of very poor quality, systolic blood pressure of about 80 and diastolic questionable. The patient was conscious, but drowsy and cyanotic. Examination of the blood showed 16.8 gms. hemoglobin, 5.65 million erythrocytes, the total white count was 6,800, but there was a noticeable shift to the left. The urine specific gravity was 1.024 with a trace of albumen, a few hyaline and granular casts, few pus and red blood cells. The CO<sub>2</sub> was

*From the Department of Pathology and Medicine, Middlesex Hospital, Middletown*

23mEq., the chlorides 112mEq. The NPN 67 mgs. per cent, creatinine 2.2 mgms. per cent.

The second postoperative day the temperature was 105°, pulse weak and thready, the respirations were rapid and shallow. An x-ray of the chest showed a collection of fluid in the left pleural cavity extending from the apex to the base. The film taken in the left lateral decubitus position revealed the presence of a flat fluid line along the lateral chest wall indicating that hydropneumothorax was present. There was little displacement of the heart and trachea, however. A left thoracentesis was done and 750 cc. of dark brown fluid plus air were aspirated. The fluid showed 4 plus guaiac, no free HCl, was alkaline to litmus paper, many pus cells but no tumor cells were found. Following the thoracentesis, a pleural friction rub was heard over the lower half of the left chest, the breath sounds were bronchial in type over the upper third of the left chest. The heart seemed pushed to the right. The heart sounds were faint and of poor quality, and no pulse was obtainable at the wrist. The blood pressure was not obtainable. The patient appeared moribund. During the remainder of the day, on three different occasions, about 500 cc. of dark brown fluid was aspirated. At 11 P. M., after a transfusion, the pulse was perceptible. The blood pressure was 115/90. The patient was responsive and breathed with grunting respirations. The Wagensteen tube was sucking out thick black fluid that was acid to litmus paper. A Foley catheter was inserted but only 50 cc. of urine obtained.

The third postoperative day the patient's condition was very poor. At 5 A. M. the pulse was weak and irregular. The patient was dyspneic and cyanotic. At 9:30 A. M. his temperature was 105°, pulse 112 weak and thready, breathing labored. The patient was semiconscious. There was a dark brown drainage of 300 cc. from the Wagensteen tube. The CO<sub>2</sub> was 15mEq., NPN 105 mgs. per cent, creatinine 8.5 mgms. per cent. The patient expired at 10:58 A. M., 72 hours after admission.

*Dr. Erslav:* How much fluid was given before and after operation?

*Dr. McLeod:* 500 cc. of blood, Vasoxcyl, 250 cc. saline during operation and 1000 cc. of 10 per cent invert sugar directly after the operation.

*Dr. Kirschbaum:* This is a very interesting case of a 57 year old, white male, who had a history of having had jaundice at the age of 22. I think we can forget about this. His next illness was diagnosed as a

peptic ulcer by x-ray. He was put on an ulcer regime, but he did not adhere to the ulcer diet. Prior to the present admission, he was ill, nauseated, unable to eat solids. Finally, the day prior to admission, he made his mistake and took solid food. On the morning of admission he vomited and had a sharp pain beneath the sternum. He was admitted to the hospital in shock. There was abdominal rigidity and tenderness and the patient presented a picture of a perforated viscus. There was an elevated white blood count. The urine was negative. A diagnosis of ruptured ulcer was made and a laparotomy was done two hours after admission. There was no evidence of fluid or air within the abdominal cavity. There was an old ulcer with adhesions. After the operation the patient did poorly and went progressively downhill. There was dyspnea, palpitation and a rise in temperature and at that time the white blood count dropped with a shift to the left. Positive urinary findings were noted: casts, elevated NPN. His heart sounds were faint and rapid. The heart was pushed to right, heart sounds of poor quality. He went into shock and became acidotic. Postoperative chest x-ray showed left hydropneumothorax. A thoracentesis was done and fluid showed no free HCl and was alkaline to litmus paper with no tumor cells. Patient expired. I think putting everything together and ruling out perforated peptic ulcer a reasonable diagnosis is rupture of the esophagus along with an old peptic ulcer.

There is a good article in the *Journal of Surgery* by Dunavant and Skinner on "Spontaneous Rupture of the Esophagus."<sup>1</sup> The term "spontaneous rupture of the esophagus" means the rupture of an esophagus presumed to have been normal. Spontaneous rupture of the esophagus is considered to be a rare event and recovery is even rarer. The first description of the lesion was made by Boerhaave in 1723 and the first ante mortem diagnosis was made by Wolger in 1914. At the present time the diagnosis has been made several times before death but seldom early enough to achieve any success with treatment. It was not until 1947 that the first case of recovery was recorded in the literature. In most cases of spontaneous rupture of the esophagus recorded in the literature no previous history is obtained to lead one to suspect disease of the esophagus.

There is a striking similarity, however, in the history, physical findings and clinical course of these patients. Most of the patients are males between the ages of 35-45 who experience severe abdominal and



chest pain, having episodes of vomiting following alcoholic excesses. The pain is constant and radiates across the upper abdomen, lower chest and into the back. Some degree of shock is usually present. Respirations are short, rapid and shallow and there is splinting of both the chest and abdomen with resulting dyspnea and even cyanosis in some instances. Tenderness and rigidity are usually present across the upper abdomen and the chest is clear for a short period of time after the rupture into the mediastinum. These signs usually continue for the first few hours and then there is a rupture into the pleural cavity which usually occurs on the left side. Only two cases were found in the literature in which the patient was operated upon before rupture into the pleural cavity. The physical signs at this time are usually those of pleural effusion on the left side. After the first few hours subcutaneous air may be palpated in the neck or noted on x-ray. This finding has been present in over 80 per cent of the cases reported but it may be transient and is easily overlooked. Also at this time there is some rigidity of the abdomen, described as boardlike in many instances. An exploratory laparotomy with a presumptive diagnosis of perforated peptic ulcer has been performed in about 15 cases due to this finding.

The article states: "The fluid obtained from the pleural cavity usually produces an acid reaction, our case being the only one reported in which an alkaline reaction was obtained." It looks like the case presented today is the second case in which the pleural fluid was alkaline. The condition of those patients who are not treated surgically deteriorates progressively and the majority will die within two days after the rupture occurs. The treatment is thoracotomy with drainage plus antibiotic treatment, or thoracotomy with repair of laceration and drainage plus antibiotic treatment.

*Dr. Bowen:* Any signs of weight loss or history of difficulty in swallowing?

*Dr. McLeod:* No.

*Dr. Bowen:* Any difficulty passing the tube?

*Dr. McLeod:* No.

*Dr. Bowen:* One might consider a carcinoma of esophagus prior to rupture, but more likely it was a spontaneous rupture of esophagus.

*Dr. Alexander:* The radiographic examination of the abdomen includes the lower chest and shows obliteration of the costophrenic sinus on the left. This with the finding of diminished breath sounds

and rales in the left chest and absence of x-ray evidence of a ruptured viscus below the diaphragm should have focused attention above diaphragm.

*Dr. Erslav:* I agree with the diagnosis of ruptured esophagus. This man had a nine year history of peptic ulcer. In effect, when he was admitted he was in severe steady abdominal pain, the abdomen was rigid and he was in shock. After vomiting in cases of increased acidity, the complication of acute esophagitis with ulcer and rupture must be considered. However, one may ask, why did the patient die? I think it is important to note he went into shock and uremia developed. We should consider the fluid balance. There was poor fluid intake. The patient had vomited several times before admission at which time RBC was 5,000,000 and hemoglobin 15.4 gms. which should make one suspicious of dehydration. At that time a Levine tube was put down, fluid aspirated through Levine-Wagensteen suction, also there was loss of fluid during the operation and 1000 cc. of fluid aspirated from chest. The following day the blood count showed 5.65M and hemoglobin of 16.8 gms. and chlorides 112mEq. indicating severe dehydration. The third day the patient continued to be severely dehydrated. The CO<sub>2</sub> was 15mEq., NPN 105 mgs. per cent, creatinine 8.5 mgs. per cent and only 50 cc. of urine obtained by catheter. I believe this patient also had lower nephron nephrosis.

*Dr. Vinci:* We have had three cases of spontaneous rupture of the esophagus<sup>2</sup> in this hospital in eight years. Two died without specific treatment because the diagnosis was not made antemortem. The diagnosis was made in the third and the patient immediately transferred to another hospital for definitive surgery.

*Dr. Frank:* An x-ray of the chest would be helpful in all cases in which an open film of the abdomen is indicated, particularly if that film showed no evidence of a ruptured viscus.

#### DR. KIRSCHBAUM'S DIAGNOSIS

Spontaneous rupture of esophagus.

#### DR. ERS LAV'S DIAGNOSIS

Acute esophagitis with rupture; lower nephron nephrosis.

#### AUTOPSY DIAGNOSIS

Spontaneous rupture of esophagus with rupture into the left pleural cavity.

Pleuritis and pneumothorax left.

Collapse of the left lung.  
 Penetrating duodenal ulcers with hemorrhage.  
 Generalized arteriosclerosis.  
 Generalized congestion.

*Dr. McLeod:* Dr. Kirschbaum has given you a good review of the subject of spontaneous rupture of the esophagus. I would like to refer you to another good article<sup>3</sup> on this subject by Dr. Mackler from the Thoracic Surgical Service of Cook County Hospital and emphasize one or two points: namely, that the diagnosis of spontaneous rupture of the esophagus should be considered in any acutely ill patient exhibiting signs of collapse and having lower thoracic or upper abdominal pain. If this occurs suddenly after vomiting and is followed by the appearance of interstitial emphysema at the base of the neck, a thoracotomy should be carried out. Of the 73 cases reviewed by Dr. Mackler only 22 were operated on. The mortality rate in 16 patients treated by thoracotomy definitive repair of the esophageal lesion and drainage of the pleural cavity was 31.3 per cent and in six patients treated by drainage alone was 66.6 per cent. Prompt diagnosis and prompt surgical intervention will improve these figures.

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### The Art Exhibit

This year the number of pieces displayed at the exhibit of the Connecticut Physicians Art Association totalled 67. For some reason not known to the editor the products of the physicians themselves appeared in the minority while wives and children made a noble effort to account for the shortage. It was a disappointment to find the exhibit diminished in size and to look for the names of many of our talented members and not find them in evidence.

The following awards were made by the jury consisting of: Mr. Sanford B. D. Low, director of the New Britain Museum of Art; Mr. Walter O. R.

Korder, president of the Connecticut Academy of Art, Hartford; Mr. L. John Wenner, assistant professor of Art at Teachers College of Connecticut.

#### ADULT OIL

First Award—Mrs. Wilson Powell, New Haven, for "Blue Skirt."

Honorable Mention—Mrs. Merrill B. Rabinow, Manchester, for "Green Ribbon."

#### PORTRAIT

First Award—Mrs. David Waskowitz, New Britain, for "Red Scarf."

Honorable Mention—Mrs. Nicholas Marinaro, Newington, for "Berthe."

#### PASTEL

First Award—Dr. John O'Leary Nolan, Hartford, for "Frog Pond in Winter."

Honorable Mention—Miss Betsy Waskowitz, New Britain for Self Portrait.

#### WATER COLOR

First Award—Mrs. Nicholas Marinaro, Newington, for "Summer Day."

Honorable Mention—Mrs. Wilson Powell, New Haven, for "Marblehead Boat Shed."

#### PHOTOGRAPHY

First Award—Mrs. Ernest Rosenthal, Hartford, for "Mother Love."

Honorable Mention—Dr. Joseph Kaschmann, Hartford, for "Lake Luzerne."

#### CERAMICS

First Award—Mrs. Gerald S. Greene, Hartford, for "Blue Lady"—plate.

Honorable Mention—Mrs. Alyce C. Kleinmann, Hartford, overglaze Tile Tray.

#### SCULPTURE

First Award—Mrs. Alexander Marsch, Hartford, for Stoneware and Driftwood.

Honorable Mention—Dr. Walter Grossman, Hartford, head of Joseph Heyman, M.D.

#### CHILDREN

First Award—Steven Rosenthal, Hartford, for "After the Rain."

Honorable Mention—Rebecca Schechtman, New Britain, for "The Sabbath."



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## Special Article

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### FLUORIDATION OF WATER SUPPLIES ENDORSED

*The statement below on the effects of fluoridation of community water supplies upon the aged and chronically ill was adopted by the Commission on Chronic Illness at its fifth annual meeting in Chicago on March 18. Creighton Barker of New Haven and James R. Miller of Hartford are members of this Commission.*

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Prevention of the occurrence of disease—or prevention of its progress—is generally accepted as the most desirable solution to the growing problem of chronic illness in this country. The Commission on Chronic Illness is interested in furthering the adoption and use of any public health measures that will contribute to the prevention of chronic illness.

Fluoridation of community water supplies has been undertaken by many communities as a public health measure directed toward the prevention of dental caries. Fluoridation of public water supplies has been endorsed by leading professional organizations in the field. Dental caries is an important chronic disease—important in terms of widespread prevalence and destruction of useful tissue—also important in the way that resulting loss of teeth may complicate the life of aged persons and persons suffering other disabling conditions.

The major portion of scientific opinion is that fluoridation of water supplies for the prevention of dental caries presents no hazard to public health.<sup>1</sup> A minority view is held by a number of qualified scientists who believe that the safety of this procedure has not been sufficiently demonstrated. Cognizant of the fact that fluoride compounds in large doses are poisonous, they advance the hypothesis that the small amounts contained in fluoridated water consumed over many years may by cumulation have subtle physiological effects especially detrimental to the aged and the chronically ill.

The Commission, concerned with the problems of chronic illness, did not feel that it could recommend

fluoridation of public water supplies without first taking cognizance of the possibility of detrimental effects. At the request of the Board of Directors of the Commission, a committee of distinguished scientists reviewed and evaluated the available evidence to decide whether at this time a positive position could be taken with regard to this hypothetical danger. The committee was under the chairmanship of Dr. Kenneth F. Maxcy, professor of epidemiology, Johns Hopkins University School of Hygiene and Public Health, Baltimore. The other members were Dr. Edward J. Stieglitz, outstanding geriatrician of Washington, D. C. and Dr. Nathan Shock, chief of the section on gerontology, National Institutes of Health, Public Health Service. This committee reports as follows:

“The basic facts concerning fluoridation which have been established by the investigations of the past 20 years have been briefly set forth in the report of the Ad Hoc Committee on Fluoridation of the National Research Council.<sup>2</sup> Under normal conditions of living, fluorine is a trace element in human nutrition. Although minute amounts are present in certain foods and beverages, a variable and important source is drinking water. Public water supplies vary widely in the amount of fluoride naturally present. Children dependent upon supplies that are low in fluorides have a high dental caries attack rate as compared to children living in communities having water supplies containing about 1 p.p.m. (parts per million) or more of fluoride. The advantage to the latter group is considerable: the incidence of caries is reduced by  $\frac{1}{2}$  to  $\frac{2}{3}$ . The caries preventive effect of adequate fluoride intake is principally conferred upon children up to the twelfth year of life, during the period when dentine and enamel of permanent dentition are being formed. However, increased resistance to dental caries is carried over into later life to an appreciable degree.

"When the trace quantities in drinking water required for optimal dental health are exceeded, undesirable physiological effects may be induced. The most sensitive indication of the latter is interference with normal calcification of the teeth, which is manifested in mottled enamel. This effect, although compatible with caries resistant tooth structure, is esthetically undesirable. The level of fluoride concentration in drinking water which is associated with the appearance of mottled enamel varies with individual susceptibility and the amount of water consumed. Under the climatological conditions of the northern part of the country it is reached when the fluoride content of domestic water supplies exceeds 1.5 p.p.m.

"In view of these facts, Trendley Dean<sup>3</sup> and his associates developed the hypothesis that by adding fluorides in proper amounts to water supplies which were deficient or low in this element it was possible to afford optimum caries preventive effect without causing mottled enamel. Controlled studies were begun in 1945, to test this hypothesis in Grand Rapids, Michigan; Muskegon, Michigan; Aurora, Illinois;<sup>4</sup> and in Newburg and Kingston, New York.<sup>5</sup> Results now available from these studies are such as to definitely establish that the protection against caries given by naturally occurring fluorides is also conferred by water to which this element has been added. Careful annual medical examinations of children in the latter study including x-rays, urine analysis, and other laboratory tests over a six year period have failed to uncover any adverse effect from fluoridated drinking water. The children in Newburgh drinking fluoridated water showed no significant deviation in height or weight growth from those in Kingston where the water was essentially fluoride free.

"The question posed by the minority of scientists is whether fluoride added to drinking water in quantities insufficient to cause mottled enamel (i.e., to a level of approximately 1 p.p.m.) have, by cumulation in tissue, any physiological effects which may be detrimental to adults and to the chronically ill. Information bearing upon this question has been derived from two sources: (1) studies on the metabolism of fluorides in man and in experimental animals; (2) observations on human populations exposed to water supplies having a fluoride content in excess of 1.5 p.p.m.

"The extensive literature dealing with metabolism and toxicology of fluoride compounds has been re-

viewed by the National Institute of Dental Research, U. S. Public Health Service<sup>6</sup> and in an article by F. F. Heyroth in the *Journal of the American Public Health Association*.<sup>7</sup> In our judgment there has been a sufficient number of observations on human subjects, with support of animal experiments, to establish the pattern of metabolism. Up to a daily intake of 4 or 5 mg. or more fluorides absorbed are almost completely eliminated in the urine and sweat. (To get 5 mg. of fluoride daily one would have to drink about 5 quarts of water containing 1 part per million of fluoride every day.) Any residual is stored in the skeletal system, teeth and bones. Little, if any, remains in the soft tissues, liver, spleen, kidneys, etc. As the level of intake is lowered, stored fluorides tend to be partially eliminated. At high levels of fluoride intake (8 p.p.m. or more) changes occur in bones which may become evident by x-ray (bone fluorosis). However, storage of fluorides in the skeletal structure in the amounts considered here results in no functional disadvantage. In other words, the body possesses two potent protective mechanisms: (1) rapid excretion in the urine; (2) storage in the skeleton.

"These studies of metabolism have been supplemented by a considerable number of observations on population groups naturally exposed for long periods of time to water supplies with varying fluoride content. In the United States, more than a million people, served by 453 different water supplies have, for generations used drinking water with a natural fluoride content from 1.5 to 8.0 p.p.m. No definite evidence has been forthcoming that continued consumption of such water is in any way harmful to health. There have been no reports of evidence of changes in bone structure when the water supply contained less than 5 p.p.m.

"In a radiologic survey of 114 persons who had lived for at least 15 years at Bartlett, Texas, where the water supply contained 8 p.p.m., 12 per cent of those examined showed minimal x-ray evidence of increased density of the bones but in no case was there any deformity or interference with function. Medical examinations, which included urinalysis and blood counts, revealed no indication that the residents of Bartlett were less healthy than those of nearby Cameron, where the water contained only 0.3 p.p.m. Reports of bone fluorosis in studies conducted in Italy, India, South Africa and Argentina indicate similar relationships to the use of high fluoride bearing waters.



"It is to be emphasized that the proponents of fluoridation of water recognize that excessive ingestion of fluorides is undesirable and that, where practical, they should either be removed by a treatment process or new sources of supply sought. They stress the necessity of keeping the fluoride content of drinking water below the level of that which causes mottled enamel, the most sensitive indication of an excess.

"On the hypothesis that a higher incidence of chronic disease would be reflected in higher mortality rates due to specific causes, the experience of cities with water supplies having a high fluoride content has been compared with that of cities having a low fluoride content. The most recent and comprehensive study<sup>8</sup> of such data is one compiled by the U. S. Public Health Service and based on the 1949-50 census reports. In this analysis of mortality rates, all cities in the United States with 10,000 population or over in 1950, whose drinking water contained 0.7 p.p.m. or more of fluoride naturally present were considered for inclusion. Each fluoride city was paired with the average of the three closest fluoride-free cities (with less than 0.2 p.p.m. fluoride) with populations of 10,000 and over. Deaths from cancer, heart disease and nephritis per 100,000 population, adjusted for age, sex and race in 28 fluoride and in 60 non-fluoride cities failed to show significant differences.

"It is the contention of the minority that epidemiological studies or analysis of vital statistics can not be relied upon to determine whether the condition of sick persons, such as those afflicted with chronic illness, particularly kidney ailments, would or would not be worsened by the ingestion of fluoridated water. Although the data are limited, experiments recently carried out at the National Institute of Dental Research on somewhat more than 50 cases who have evidence of damaged kidney function and who use drinking water containing 1 p.p.m. of fluoride have come to our attention. The results indicate that the excretion pattern of fluorides in these patients with damaged kidneys is similar to that reported by McClure<sup>9</sup> for healthy young men. The collection of negative evidence such as this for an absolute determination of no possible effect of fluorides in persons suffering from chronic illnesses is an endless and extremely complicated undertaking. Generally speaking, consideration of the primary

factors in the causation of such illnesses far overshadows any minor or secondary effects which, in the light of present knowledge, could be assumed from ingestion of trace amounts of fluoride in drinking water."

The Commission has been advised by the foregoing expert opinion that extensive research into the toxicology of fluorine compounds has revealed no definite evidence that the continued consumption of drinking water containing fluorides at a level of about 1 p.p.m. is in any way harmful to the health of adults or those suffering from chronic illness of any kind. While the evidence does not absolutely exclude this possibility, if a risk exists at all it is so minimal and inconspicuous that it has not been revealed in many years of investigation. The Commission, therefore, urges American communities to adopt this public health measure as a positive step in the prevention of the chronic disease, dental caries.

The fluoridation of water supplies involves no new experience in human welfare. Over 3,000,000 people are living in ordinary good health on water naturally containing fluorides in the amounts recommended for caries control, or more.

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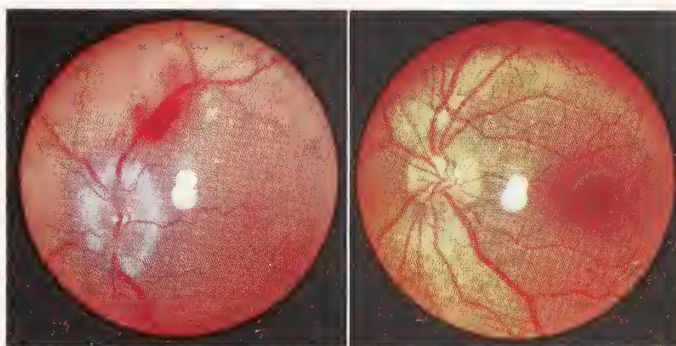
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Diastolic pressure reduced to level considered normal in one-quarter and to 110 mm. Hg or less in one-third of 97 patients receiving oral Apresoline for periods ranging from 3 months to 1 year or longer;<sup>1</sup> hypertension in which neurogenic or psychogenic mechanisms predominated most improved; patients with severe as well as moderate hypertension benefited.

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Lessening of retinal arteriolar constriction; disappearance of retinal hemorrhages; remittance of hypertensive headaches, giddiness, paresthesias, transient pareses, and encephalopathies; some evidence of improved mental alacrity.

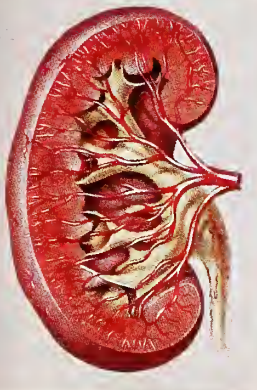


### APRESOLINE INCREASES RENAL BLOOD FLOW

Renal improvement less marked than cerebral improvement, but renal blood flow and filtration rate increased and hematuria and proteinuria remitted in some cases; hypertensive heart disease little improved and, in some cases, worsened.

*Side Effects:* Side effects "minor, transient, or remediable" in most cases.

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\*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

C I B A





#### **ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES**

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin<sup>1</sup> found Pyribenzamine beneficial in 82% of 107 patients; Feinberg<sup>2</sup> noted relief in 82% of 254 cases; Gay and associates<sup>3</sup> in 76% of 51 cases; Arbesman and colleagues<sup>4</sup> in 84% of 106 cases. In a later study Arbesman<sup>5</sup> rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."<sup>6</sup> Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

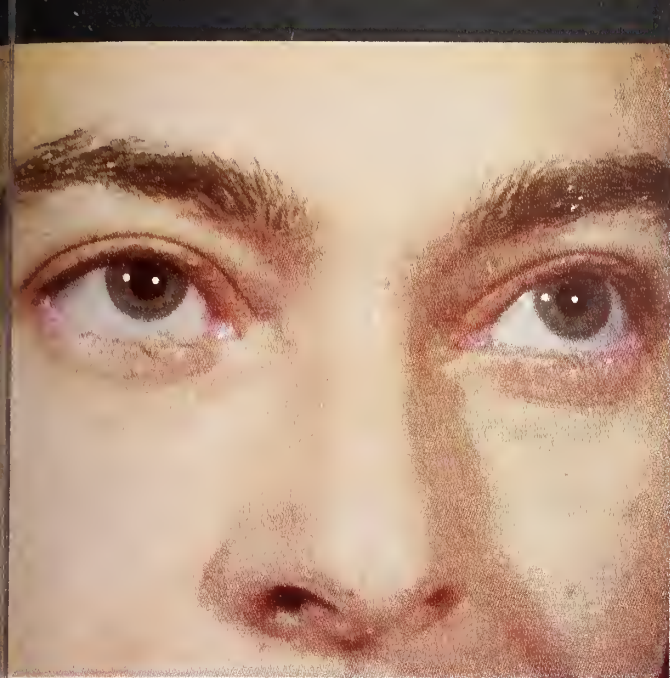
#### **CONTROLS PENICILLIN REACTIONS**

Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten<sup>7</sup> found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

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PYRIBENZAMINE CITRATE (TRIPLENNAMINE CITRATE CIBA)

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For complete information on Pyribenzamine ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J.





**INCREASES PERIPHERAL BLOOD FLOW:**

Priscoline reported to be a valuable aid to conventional therapy in peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, other trophic manifestations; Priscoline most effective when vasospasm is prominent but may prove limb-saving even when vasospasm is minimal because it decreases vascular tone, promotes establishment of collateral circulation.

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Priscoline exerts direct vasodilating effect on vessel wall, blocks sympathetic nerves (probably at their terminations in vascular muscle), blocks vasoconstrictive action of circulating epinephrine-like substances.

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**AGE 75.** Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



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Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.

**AGE 68.** Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.



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## NEWS FROM WASHINGTON

### AMA Testifies on Health Bills Before Senate Subcommittee

Dr. David B. Allman, chairman of the AMA's Committee on Legislation, on April 13 testified before the Senate Labor and Welfare Committee's Health Subcommittee on four of the major health bills proposed by the Eisenhower administration. "In general, we agree with the stated purposes of these proposals," Dr. Allman said, "but we believe that considerable more study is necessary to determine the most desirable ways to accomplish these objectives." Following is a summary of Dr. Allman's testimony on each of the bills:

**S2778—Public Health Grants.** The bill proposes that the present grants for designated diseases be eliminated in favor of three new types of grants, (a) for public health services in general, (b) for extension and improvement of services, and (c) for "unique projects," or pilot operations. Dr. Allman recommended that the proposed new type one and two grants be lumped together, with the state public health officer using the funds as he sees fit, and that the Public Health Service surgeon general be required to consult with state health authorities or an advisory committee before allocating money for type three projects, which could be given to private as well as public projects. He also recommended that "only a small percentage of funds" be earmarked for type three grants.

**S2748 and HR8149—Hill-Burton Expansion.** Dr. Allman suggested that the Senate bill be amended to include a declaration of purpose similar to that in the House-passed measure, reaffirming that installations are for use of the entire community. He also called for a clarification of the relationship between priorities in the present act and those in the proposed measure, and for more specific definitions. He declared: "In particular the definition of 'diagnostic or treatment centers' is vague and ambiguous. It is not clear whether 'a diagnostic or treatment center' will include an individual physician's office, a group clinic, operated by physicians, or any hospital. How will the inventory be made by states under vague terminology of this type? We consider

the language of this part of the bill to be an unwise amendment to an act which has been highly successful to date."

**S2759—Vocational Rehabilitation.** The bill would change the method of making grants to states in the interest of better administration. Dr. Allman told the committee that the Association "has not received a sufficiently clear explanation to permit formation of a final opinion on the bill." He said AMA "has no position on the proposal at this time."

**S3114—Reinsurance.** Dr. Allman gave complete indorsement to the stated purpose of the bill, to promote the best possible medical care on reasonable terms. This, he said, has also been an objective of the AMA. Dr. Allman recounted progress of voluntary health insurance, then said he thought the future holds real promise for still greater progress. He concluded: "It is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies."

### Bill Would Bring All Employers Under Unemployment Program

Legislation introduced by Chairman Reed of the House Ways and Means Committee would require all employers, even of only one person, to participate in the federal-state unemployment compensation program. Under present law, employers are required to participate only if they have eight or more employees. The only physicians exempted under the bill would be those with no employees. Under present law, employers may report and pay the tax quarterly or annually; the bill would eliminate the quarterly system. The U. S. tax is 3 per cent of the payroll, but a credit of 2.7 per cent is allowed employers, providing they pay this amount as state unemployment taxes. The bill (HR8857) has the administration's support. The committee is expected to be busy several weeks in executive session on the social security extension bill. Accordingly, no hearing date has yet been set for the compensation measure.



**HR8300—Internal Revenue Code of 1954.** (Reed, New York.) The Senate Finance Committee, which has been holding extensive hearings on the House-passed income tax revision bill, has received endorsement from the American Medical Association of the section increasing medical expense deductions. Dr. George F. Lull, secretary and general manager of the AMA, wrote Chairman Millikin that the AMA had supported such legislation for some years. The bill would allow a taxpayer to deduct medical expenses in excess of 3 per cent of adjusted gross income instead of the present 5 per cent.

Dr. Lull added: "The Association likewise favors the inclusion of prepayment health insurance premiums as part of medical expenses for tax purposes. This provision will serve as inducement for more families to join voluntary medical and hospitalization plans . . . and will help reduce or eliminate the financial burdens of long and costly illness. . . . Most important of all it will encourage the voluntary approach to the solution of health problems rather than promote more dependence on government."

### Medical Care for Military Dependents

Just a little more than a year ago the Moulton Commission started its study of medical care for military dependents. After a series of hearings, it made its report in June. The long delayed bill to implement the recommendations contained in the report has just been introduced in the Senate and is reported here in detail. In many respects it is not too far away from the policy of the American Medical Association regarding dependent care, but on one basic point there is disagreement; Defense Department would have dependents receive private medical and hospital care only if they couldn't be handled in military facilities, whereas AMA would have them use military facilities only if care were not available from private sources. It would be well to familiarize yourself with this legislation. Even if nothing is done this session, medical care for dependents will probably continue as an issue until Congress does take some definitive action.

**S3363—Armed Forces Dependents Medical Care Act of 1954.** (Saltonstall, R—Massachusetts, April 27.) Drafted by and introduced at request of Defense Department, this Administration measure is designed to provide a "uniform program of medical care for dependents" as an important factor in Armed

Forces morale. Currently, extent of medical care to dependents varies geographically and within the services. The bill provides:

**Medical Care Authorized:** Diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care.

**Not Authorized:** Hospitalization for domiciliary care and chronic diseases, nervous and mental disorders (except for diagnosis), "elective medical and surgical treatment." No prosthetic devices, hearing aids, orthopedic footwear or spectacles, except abroad or at remote stations, when sale would be at cost; no home calls except in special cases; no ambulances, except in acute emergency.

No dental treatment in military facilities, except emergency care or as necessary adjunct to medical treatment or at remote stations and abroad. No dental care from private sources, except as necessary adjunct to in-patient medical treatment.

**Civilian vs. Military Care:** Dependents to be cared for by civilian physicians and at civilian hospitals only if care is not adequate or available in military facilities. Amount of care to be provided by military would be "subject to availability of space, facilities and capabilities of medical staff." Except for charges to dependents noted below, U. S. would pay civilian physician and hospital costs, in line with a fee schedule to be set by Defense Secretary who may consult with medical and other groups on the schedule.

**What Dependents Pay:** When care is from civilian sources, dependents pay first \$10 for each illness (except maternity), and in addition, not more than 10 per cent of total cost; in military installations, Defense Secretary to set charges to dependents, "pursuant to a special finding that such charges are necessary." Subsistence in connection with medical care to be paid for as prescribed by regulations. U. S. to stand balance of expense.

**Dependents Defined:** Declared to be eligible for care are the wife, unmarried children, adopted or step children under 21, and those over 21 if physically or mentally incapacitated and dependent on service member for over half support; parents and parents-in-law if dependent for over half of their support; widows and dependent children of members who die while eligible under the act (but such dependents eligible only for care in military facilities).

**"Members of Armed Forces" Defined:** All persons on active duty in three services (and Coast Guard

when operating as part of Navy); reserves on extended active duty of more than 90 days; retired members of services, except those retired on reserve retirement point program. The Secretary of Defense is authorized to promulgate regulations subject to approval by the President. To Armed Services Committee.

**HR7397—Public Health Service Grants.** (Wolverton.) On April 27 the House passed by voice vote the Public Health Service grants bill with committee amendments. The committee's report on the bill was filed on April 23, debated April 26, and passed April 27. As reported, the bill was amended to maintain mental health grants as a separate category for five years. Reason given: the magnitude of the mental health problem, the early stages of the program, and separate mental health divisions in several states make it advisable to earmark appropriations for those activities. The amendment thus continues for five years the present system for dealing with mental health grants. The committee also amended the bill to give the states the right of judicial appeal, as in the Hill-Burton Act.

### **President Agrees to \$25 Million Hill-Burton Increase**

President Eisenhower will recommend that Congress increase these three health program appropriations for fiscal 1955: Hill-Burton hospital construction from \$50 million to \$75 million; vocational education from \$17.5 to \$18.6 million; and Public Health Service grants (tuberculosis, venereal disease, etc.) from \$19.4 million to \$22.8 million. Announcement that the administration would not insist on holding to the Budget Bureau's figures was made by Senator Thye before a session of the appropriations subcommittee of which he is chairman. The new figure for Hill-Burton would be \$10 million higher than the current appropriation, but the other two changes would in effect bring the programs up to the current level of spending. The Hill-Burton appropriation would be applied only to grants for hospitals; legislation passed by the House and pending in the Senate Health Subcommittee to extend the Hill-Burton program would require additional appropriations. The administration made no mention of increasing the funds for vocational rehabilitation, inasmuch as legislation to expand this program is pending in House and Senate. If the legislation is adopted, vocational rehabilitation appropriations

would be increased from \$19.5 million to \$23 million or more.

### **Full Pay to VA Residents**

Rep. Rogers, who is chairman of House Veterans Committee, has introduced a bill (HR8987) authorizing regular staff pay for medical residents training in veterans hospitals. Present salary range is \$2,640 (first year) to \$3,300 (third year), with trainee paying own subsistence. Rogers bill would put residents on full staff scale, whose floor is \$5,500 and ceiling \$8,360. Actually senior and chief grade physicians in VA get upward of \$9,600 but residents probably would be pegged in rank of intermediate (\$8,360) and below. Proposed salary increase would be limited to residents who had any active duty in Medical Corps of Army, Navy or Air Force subsequent to December 7, 1941. A retroactivity clause gives pay raise even to doctors now in VA employ who have completed residency training.

To promote postgraduate education in psychiatry, leading to board certification, VA has had a similar program in force for some time, but only in this one specialty. Rogers bill's cost—running into millions per year—mitigates against its acceptance by Budget Bureau, even if it were to be indorsed by VA.

### **Intergovernmental Commission Setting Up Health Committee**

Federal-state responsibilities in the field of health will be studied by a special committee now being formed by the Commission on Intergovernmental Relations. The 10 man group will include three commission members. Four research organizations are also reviewing the administrative, fiscal, and political aspects of federal grants-in-aid programs, and are expected to report to the commission within the next few months. Formerly headed by Clarence Manion, the commission now is under the direction of Meyer Kestnbaum. George C. S. Benson, commission research director, called his group's study of division of health responsibilities "the most substantial program ever undertaken in the field" in a speech before the U. S. Chamber of Commerce.

### **Supreme Court Upholds Suspension of New York Physician**

In a 6 to 3 decision, the U. S. Supreme Court has upheld the New York State Education Department's



medical grievance committee in the six month suspension from practice of Dr. Edwin K. Barsky. The suspension followed Dr. Barsky's 1947 conviction for contempt of Congress, after his refusal to give the House Un-American Activities Committee information on the Joint Anti-Fascist Refugee Committee, of which he was national chairman.

### **BLS Index Shows Rise in Medical Care Cost**

Consumer price index for March, published recently by Bureau of Labor Statistics, reveals slight rise in costs of medical care (including hospitalization and certain drugs). Latest index figure is 124.4, compared with 124.1 in February and 119.5 for March, 1953. Consumer prices as a whole dropped 0.2 per cent between February and March. Of eight categories on which statistics are kept, only one—transportation—had a higher index figure (129.0) than medical care.

Further comparisons, however, disclose that costs of medical care—over a longer haul—have not gone up as much as other items. They are 71.3 per cent higher than they were in 1939, but transportation has risen 87.2 per cent, apparel 98.7, personal care 91.4, reading and recreation 71.7 and food 138. All categories combined are 93.3 per cent over 1939.

### **Formula for Gamma Globulin Allocation Is Set**

Gamma globulin as an antipoliomyelitis weapon, in greater supply this year, is being allocated among states by Public Health Service on following basis: 45 per cent of supply earmarked in proportion to total number of cases in 5 year period 1949-53; 45 per cent to be apportioned by a more complex formula, key factors including past incidence among children and participation in vaccine field trials; 10 per cent to be placed in contingency reserve for availability upon special request. First shipments went out to state health departments recently and next consignments are due on or about June 1.

### **FDA Obtains Ban on 2 More Misbranded Drugs**

Food and Drug Administration discloses, in its March report, Federal court victories against two more proprietary medicinals. Injunctions have been granted to bar shipment of products marketed as "Garlex" and "No-Fast." Former is a liquid garlic

compound represented as treatment for tuberculosis, hypertension, colitis, typhoid and other diseases. The other, according to FDA, is a yellow ointment of petroleum, salt, honey and antacids that was promoted as self medication for stomach and duodenal ulcers.

### **Military Affairs**

The National Advisory Committee to Selective Service reminds that all Priority I and II physicians, and Priority III men 32 years of age or under, "in all probability" will be called to duty between next July 1 and June 30 of 1955. The committee also emphasizes that delay in commissioning necessitated by new regulations makes it important for all men finishing their internships and residencies to apply at once for commissions. In this connection, the Navy has asked Selective Service to call up 480 physicians in June and 120 in July.

Selective Service says Priority I pool will be ample to supply all 360 "draft doctors" requisitioned by Navy for June delivery and the 120 ordered for July activation.

### **Inaugural Ceremony Broadcasted**

The inaugural ceremony at which Dr. Walter B. Martin, Norfolk, Virginia, will be installed as the 108th president of the American Medical Association will be broadcast over a nationwide radio network on Tuesday, June 22.

Originating at 7:30 P. M., Pacific Coast Daylight Saving Time, (10:30 P. M. Eastern Daylight Saving Time) from the Palace Hotel in San Francisco, the program will be carried by more than 350 stations of the American Broadcasting Company's radio network. This will be the fifth consecutive year an AMA president has addressed the nation on the night of his inauguration.

This year, for the first time, the ceremony also will be televised by a local station. KGO-TV will carry the program to television viewers in the San Francisco area.

In addition to Dr. Martin, other AMA officers who will appear on the radio and television broadcasts are Drs. Dwight H. Murray, chairman of the Board of Trustees; Edward J. McCormick, outgoing president, and James R. Reuling, speaker of the House of Delegates.

# TO HELP TELL THE STORY



## EMERGENCY MEDICAL CALL PLANS

This exhibit is on a tour of Connecticut to help tell the story of emergency call plans sponsored by local medical associations.

It is now being displayed in the lobbies of hospitals in Hartford County, under auspices of the Hartford County Medical Association. The Woman's Auxiliary is cooperating in the program, which will include similar displays in other counties.

Leaflets describing the emergency services are furnished with the exhibit for public distribution.

*Note: Emergency plans in Meriden and Norwich have been added to the exhibit since the above picture was taken.*



## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold J. Bergendahl, Norwich

Burdette J. Buck, Hartford  
James C. Canniff, Torrington  
Morris A. Hankin, New Haven

Harry C. Knight, Middletown  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

### New Sound Film, "Your Doctor," Screened For Community Groups

The fifteen minute sound film, "Your Doctor," produced by the American Medical Association and RKO-Radio Pictures, is being shown at an increasing number of organizational meetings throughout the State.

Dr. Alfred T. St. James, Wallingford, presented the film at a 60 member meeting of the Wallingford Rotary Club on May 5. The following week the film was shown several times in Derby during a community program sponsored by the Griffin Hospital in observance of National Hospital Week.

The film also has been shown before a number of high school audiences and industrial groups. It is available without charge except for return postage. Organizations desiring to borrow the film must provide their own sound projector, screen and operator. Physicians who wish to use the film as part of a speaking program are requested to reserve a copy through the State Medical Society's Public Relations Department as far in advance of the meeting date as possible.

The production portrays the progress of medicine, the education of medical students and advancements in medical care. In its original 35 mm. version, it was screened last year in more than 5,000 community theaters.

### AMA Surveys Use of Television Films

The Bureau of Health Education of the American Medical Association is conducting a survey among medical associations to determine the most effective methods of utilizing television for health education. The Bureau has several films available for television use by local medical associations, also scripts and outlines that may be used in planning local television programs. Information concerning the types of material available, all of which is furnished without cost to local associations, may be obtained at the offices of the State Medical Society.

The exhibit portrays the growth of emergency call plans, now available to 75 per cent of Connecticut's residents. An illuminated map of the State indicates the location and telephone numbers of the 15 major emergency plans now sponsored by county and local medical associations.

Leaflets describing the plans and the services they offer residents are available for distribution with the exhibit.

### New Haven PR Committee Studying New Plan

The Public Relations Committee of the New Haven County Medical Association is studying a plan to coordinate actions with similar committees of local associations in the development of community services.

As presently contemplated, the plan would call for representation of local associations on the county committee. Dr. James H. Root, Jr., Waterbury, chairman of the committee, has explained that one objective of the plan would be to assist local committees to obtain information concerning the experiences of other medical groups. Planning of new activities would then be based on combined experiences and this should prove helpful in assuring successful operation.

### Exhibit on Emergency Services Displayed at Hartford Hospital

The first public display of the Society's new exhibit on emergency medical call plans sponsored by local medical associations was conducted at the Hartford Hospital during the month of May.

Displayed under auspices of the Hartford County Medical Association, the exhibit was installed in the lobby of the hospital, viewed by several thousand persons from the Hartford area. The exhibit will be displayed at other hospitals in Hartford and Hartford County and will then be sent to another county for similar display.

## FROM OUR EXCHANGES

Garland offers an interesting outline of the history of medicine in New England (*J. Okla. State Med. Assoc.*, 46:6). He continues with the observation "that events that have had their place in shaping the course of medical progress are part of our total heritage, regardless of the locality in which they happened to originate."

\* \* \* \*

There have been about twelve cases of so-called "salt losing nephritis" reported in the medical literature (Murphy et al., *Ann. Int. Med.*, 38:6). The authors observe that many patients show the chemical evidence of a salt depletion in the blood serum, but that the clinical features of the salt depletion, such as collapse, hypotension, muttering delirium, mental confusion, weakness and painful extremities, may not yet have developed. The one physiologic feature common to the four cases reported was disturbance of the tubular system, namely, the failure to conserve sodium and chloride in the normal way. As this failure has been considered in some cases to be associated with manifestations of Addison's disease, the differentiation from Addison's disease has been in the author's cases a diagnostic problem. It appears wise in the opinion of the authors to suspect this salt-losing syndrome in all cases of chronic renal insufficiency with impending uremia, and to be aware of the condition in these days when restriction of salt has become a popular form of treatment of nephritis, of edema, of heart disease and of hypertension. The recognition of this abnormality, followed by adequate treatment, may lead to gratifying therapeutic response and years of comfort added to the life of the patient.

\* \* \* \*

Discography in "The Diagnosis of Herniation of the Lower Lumbar Intervertebral Disc" is a procedure that is recommended by Davies and Peirce (*Ill. Med. Jour.*, 104:2). A fine lumbar puncture needle is inserted through the posterior annulus fibrosus in any of the three lower lumbar spaces. An absorbable contrast medium may be injected to outline the nucleus pulposus. This procedure is called discography and makes possible the demonstration of various types of disc pathology, especially hernia-

tion. The authors believe that discography is a valuable adjunct in the diagnosis of ruptured intervertebral disc and probably more accurate than myelography in the verification and localization of herniations.

\* \* \* \*

Smithers in a discussion of "Cancer of the Lung" concludes that the startling rise in the recorded death rate of lung cancer is in large part due to change in number and age of the population and to improved diagnosis (*Brit. Med. Jour.*, 4822). There is, however, a real increase but Dr. Smithers believes that we are not yet in a position to say how great that real increase is. A sensible view of the relationship of smoking to this problem should be and, after some wild comments in the lay and medical press, is now being presented to the public. Dr. Smithers continues with the observation that there seems to be no comparable effort put forward to persuade the public authorities to cleanse the air of our industrial towns. Surgery, radiotherapy and chemotherapy offer relief or even cure only to the fortunate few.

\* \* \* \*

An editorial in *New York Medicine* (IX:1) gives some good advice on the prevention of malpractice complaints. Some of the points made are:

- (1) Maintain adequate office and hospital records.
- (2) Demand adequate consultations.
- (3) The adequate use of x-ray examinations especially in cases of suspected or possible fracture.
- (4) Practicing well within one's field of professional competence.
- (5) Avoidance of experimentation except within the setting of organized clinical research.
- (6) Avoidance of undue admissions of failure and deprecating the professional care of others.
- (7) Avoidance of harsh business methods especially as these pertain to fees and collections.
- (8) Insistence upon acceptable hospital standards.

The editorial points out that the physician must be on his guard when dealing with the new patient and the disgruntled or dissatisfied patient, old or new. It is well to remember that every patient is a



potential claimant and every end result which is less than perfect may become the basis of a malpractice claim.

\* \* \* \*

Senturia believes that the nasopharynx and its contained adenoid tissue is a source of many of the persistent problems which the practitioner is called upon to treat (*Jour. Mich. State Soc.*, 52:7). The adenoids are considered as a potential source of infection and obstruction causing or contributing to nasal congestion, sinus infection, tympanitis, middle ear disease and deafness. For these reasons Dr. Senturia suggests that more and better adenoidectomies receive serious consideration.

\* \* \* \*

Farmer's Lung as described by Studdert is, for one doctor at least, an unfamiliar medical term (*Brit. Med. Jour.*, 4823). The onset of the illness is acute and there is a tendency to spontaneous recovery in a period of six to eight weeks. The clinical picture is that of a patient in distress. He is blue and dyspnoeic and examination reveals widespread crepitations throughout the lungs. Radiologically the picture is one of increased lung markings with superimposed soft shadows.

The author stresses the similarity of "farmer's lung" to coniosporiosis, byssinosis, and diffuse granulomatous pneumonitis. The theory is advanced that "farmer's lung" is a nonspecific lung reaction to some material in the fungus-laden dust, rather than a true fungus infection of the lungs.

\* \* \* \*

Smith makes the statement that stilbamidine will cure patients with advanced disseminated blastomycosis (*G.P.*, VIII:1). The immediate toxic reaction can be prevented by diluting the drug in 100 to 300 ml. of 5 per cent glucose in distilled water or normal saline and administering by slow intravenous infusion over a period of one to three hours. The total dose of the continuous type therapy is about 4 Gm., and in the intermittent type from 4.5 to 6 Gm. Destructive lesions of the liver and kidney are prevented by protecting the drug from sunlight. The chief complication in the experience of the author was development of neuropathy of the sensory portion of the fifth nerve some three to five months after cessation of therapy.

\* \* \* \*

"The Polio Problems and their Medical Management" is discussed by Batson in two parts in the *Amer. Pract.*, (4:4-5). Part I of the series is a superior presentation of the clinical course and treatment of the acute phase of the disease. It is deserving of emphasis that, while poliomyelitis is primarily a disease of children, it may nevertheless occur in any age group. The incidence in young adults is almost the same as that in older children. Poliomyelitis may occur at any season of the year.

The author points out that a lumbar puncture is probably not indicated if the diagnosis is firmly established on a clinical basis. If there is doubt as to the diagnosis, there should be no hesitation in doing a lumbar puncture as there is no evidence that the needle trauma favors progression of the disease or involvement of the lumbar musculature, unless it be on the basis of an exhaustive procedure.

In Part II Dr. Batson considers the care of poliomyelitis. He analyzes at some length the pros and cons of home care as against hospital care. The author favors the home care of these patients wherever possible; and seems to think that it is always the wise choice in the nonparalytic and the mildly paralytic patient. The care of the seriously ill must continue as a hospital problem (bulbar and respiratory failure are cases in point).

Dr. Batson points out that, except for rest, there is no regimen and no drug that can alter the course of the infection.

\* \* \* \*

"An Outbreak of Diphtheria; Influence of Immunization" was studied by Lycett and George (*Brit. Med. Jour.*, 4817). In the town of Cosely there were 108 cases of serious diphtheria with 6 deaths in the year 1951. Long term carriers appeared to play no part in the spread of the epidemic. It was thought that the infection was spread mainly in the home rather than in the schools. The outbreak emphasized the importance of a constant watch upon the proportion of children receiving reinforcement of diphtheria antigen. The epidemic occurred in a district in which at least 73 per cent of the school population had completed a course of immunization at some previous time. It is stressed that this outbreak of diphtheria provided evidence that the risk of severe illness or death was reduced for those who had at any time been immunized. In the two areas most affected the incidence of diphtheria fell immediately after mass immunization of the school population.

Cardiospasm is almost the forgotten disease. Olsen et al. found 601 cases in a period extending over 12 years (*Dis. of Chest*, XXII:5). The diagnosis of cardiospasm is not difficult even in the early stages. If the physician pays proper attention to the patient's symptoms and if an adequate roentgenologic examination of the esophagus is made, the diagnosis should be detected in every case before the "decompensable phase" develops. Too often the patient's dysphagia has been regarded casually and considered to be a purely functional symptom. Cardiospasm is a pathological entity and should not be treated lightly or not at all. Satisfactory methods of treatment are available, especially in its earlier stages and "physicians should recognize the disease in its earlier stages and see that it is treated promptly."

\* \* \* \*

"Hypotension Induced by Hexamethonium Bromide" involves some risks. Schweizer (*N. Y. State Jour. Med.*, 53:17) believes that reduction in the blood pressure below a minimum of 60 mm. Hg. carries with it a definite risk of impairment of kidney and liver function. Patients with pre-existing renal or hepatic disease are in greater danger, and the critical point should probably be placed at a higher level. Since the evaluation of the physiologic changes produced by a state of "controlled" hypotension is still at an early stage, it is preferable to reserve this technic for patients with good cardiovascular, renal, and hepatic function and for operative procedures in which the advantage of reduced bleeding outweighs by far the known dangers of the method.

### Dr. Lyman Again Honored

David Russell Lyman, whose name has been synonymous with Gaylord Farm for fifty years, was presented the 19th Annual Gold Medal Award by the New Haven Advertising Club for "distinguished service to the community." The presentation was made at a dinner at the Woodbridge Country Club on April 20. The guest speaker of the evening was Hon. Carroll C. Hincks, U. S. Judge, Second Circuit. The medal presentation was made by Governor Lodge.

Physicians present were Gustaf E. Lindskog, Martin Heinemann, and Marvin M. Scarbrough from New Haven, and Paul S. Phelps and Stanley B. Weld from Hartford.

### Wesleyan Selects Dr. Clair Crampton

Clair B. Crampton, M.D. of Middletown, has been appointed dean of freshmen of Wesleyan University, effective September 1954. Dr. Crampton will have charge of the counselling of Wesleyan first-year men in academic and personal problems. He will succeed Dr. Herndon Wagers, who leaves Wesleyan in June to become professor of the philosophy of religion at Southern Methodist University in Dallas.

Dr. Crampton, who will devote part time to his new Wesleyan duties, will continue his association with Drs. G. M. Craig, A. W. Thomson, and William Sweeney.

He will carry on, in his new position, a long interest and participation in Wesleyan affairs. A native of Middletown and a graduate of local schools and Middletown High School, Dr. Crampton was graduated from the college in 1929 and received his master of arts degree in 1931. He joined the Wesleyan faculty in 1931 and taught biology until 1933 when he entered Yale Medical School. He received his doctor of medicine degree from Yale in 1937.

He has been director of student health at Wesleyan since 1950 and in that capacity has been active in student counselling and in the deliberations of the college Administration Committee.

After a year of internship at New York Hospital, Dr. Crampton served as assistant resident in surgery at New Haven Hospital from 1938 to 1940 and as a resident specialist from 1940 to 1941. In 1942 he was a clinical instructor on the staff of the Yale Medical School.

He returned to Middletown in 1942 to join Dr. Craig. His local practice has been continuous since then, with the exception of service as senior surgeon of a Navy LST group in the Pacific from 1943 to 1945.

He is co-chief of obstetrics and gynecology at Middlesex Memorial Hospital and attending gynecologist at Connecticut State Hospital.

### Agnes Ohlson Becomes President of ANA

Miss Agnes Ohlson, R.N., of Hartford was elected president of the American Nurses Association at the convention held in Chicago the last week in April. Miss Ohlson is chief examiner and secretary of the Connecticut Board of Examiners for Nursing and was elected over her opponent, Mrs. Myrtle H. Coe, R.N., assistant professor of nursing at the University of Minnesota School of Nursing.



## Rehabilitation Consulting Committee Named

Eleven leaders in community affairs, medicine, business and social welfare were named by State Commissioner of Education F. E. Engleman to serve in an advisory capacity to the State Bureau of Rehabilitation.

This action is an expression of the ever increasing responsibility of the role of rehabilitation as it affects many community endeavors. The effectiveness of rehabilitation in turning the dependent into wage earners has attracted the attention of community leaders who see in rehabilitation a new modern tool to curb human waste and substitute rehabilitation for relief wherever possible.

The new committee members are: Creighton Barker, M.D., State Medical Society; Frederick Gutmann, Textile Workers Union; Howard Houston, State Welfare Commissioner; Elizabeth Irwin, Connecticut Federation of Labor; Philip Laing, Aetna Casualty and Surety Co.; Frank Murphy, National Foundation for Infantile Paralysis; Leo Noonan, Workman's Compensation Commission; Col. Raymond Watt, Veterans Home and Hospital; Walter Wenkert, T.B. and Health Association; J. Harry White, Bard-Parker Co.; Vincent M. Zanella, Jr., Attorney at Law.

## Hospital Privileges for General Practitioners

The Massachusetts Academy of General Practice recently conducted a survey to ascertain if possible just how adequate are the hospital facilities available to the general practitioner. It was learned that 81.1 per cent of this group considered their hospital facilities adequate for the care of their patients, 14.9 per cent had inadequate facilities, and 4 per cent had no facilities. This is an improvement of 7.1 per cent in the past three years for those with adequate facilities and a change from 21 to 4 per cent in the same three year period for those with no facilities.

Another interesting observation: of the 796 replies received from a questionnaire sent out to 1,300 physicians, it was learned that 418 were active members of a hospital staff, 85 were associate members, 255 were on the courtesy staff, and 14 were consultants. Of these only 114 felt their privileges

were inadequate and 36 of these were members of the active staff.

The final touch came in this discovery that of those replying to the questionnaire only 46 general practitioners have been in practice five years or less. With the majority of medical students pointing toward some specialty, the question might well be asked, "Who will be the general practitioner of the future?"

## Medical Students Training at Army Hospitals

For six weeks this summer three of the Army's largest hospitals will be hosts to forty-five junior and senior medical students. These students will familiarize themselves with the high standards of military medicine practiced in Army hospitals and, in addition, receive instruction in internal medicine and in surgery and their subspecialties. Classroom instruction will be kept to a minimum so as to permit them to spend most of their time in clinical patient care under the guidance of the assigned staffs. Each of them will devote forty hours a week to curricular activities. However, any student may volunteer for additional time in which to gain more knowledge and experience.

This program, which has been given the title of Clinical Clerkship Training Program, will become effective on July 15 at the Walter Reed Army Hospital, Washington, D. C.; the Letterman Army Hospital, San Francisco, California; and the Fitzsimons Army Hospital, Denver, Colorado. Each of these hospitals will be host to fifteen students. Selected medical schools within the geographical areas of the hospitals have been requested to nominate principal and alternate students for voluntary participation in the program.

Participating students will be carried on a "student-employee" status under Civil Service. Each student will be paid at the rate of \$183 per month, from which amount will be deducted the cost of living quarters, subsistence, and laundry. Uniforms will be furnished by the hospitals. Travel to and from the hospitals is at the expense of the students. The students' obligations for military service will not be affected by participation in the program.

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# ANNUAL REPORTS

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

### 1953-1954

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#### REPORT OF THE PRESIDENT

It is useless for me to attempt any detailed account of the activities of the Society for the past year during which I have been president. These activities are too numerous, and to present the details to you would be as useless as well as a tremendous task. Such facts are in the various committee reports and in the minutes of the Council meetings, all of which are published in the CONNECTICUT STATE MEDICAL JOURNAL, where anyone who is so minded can read about them. However, I would like to emphasize and draw your attention to certain problems and developments which in my opinion are important, or in which I am especially interested.

In July the Connecticut Hospital Service gave notice of the termination of the agency agreement between Connecticut Hospital Service and Connecticut Medical Service. In spite of this action Connecticut Medical Service immediately went forward with plans to operate independently in a home of their own. This change was fully discussed at the semi-annual meetings of the County Associations last fall. A revised contract was presented by the Professional Policy Committee on December 9, 1953 which would supply the increased demands for further benefits. Following the results of a referendum of the participating physicians the new contract was offered for sale. Connecticut Medical Service at the end of five years has paid out to doctors a total of over \$15 million, and has an enrollment of about 800,000 members. The Society should be proud of the fine results that CMS has achieved in these five years.

At the Council meeting on November 19 a communication was presented from Mr. Hugh DeHaven, director of crash injury research at Cornell University Medical College, outlining proposals for a study of automobile crash injuries to be undertaken in Connecticut. An advisory committee was appointed and the project approved. With the rapidly growing number of automobile accidents a study of this sort should be of vital importance and offer unlimited possibilities. Certainly the doctors of Connecticut should take an active part in this investigation.

The Council decided to recommend discontinuing of the Nursing School Scholarships as awarded last year and to provide five Medical School Scholarships of \$500 each for the year 1954-55. As before, these scholarships are to be awarded to young men or women whose homes are in Connecticut and who are enrolled in the fourth and final year of an approved medical school in the United States or Canada. The sum of \$2,500 will be taken from the surplus funds of the Society. This is an extremely worthwhile endeavor and should have the backing of every delegate present today.

The Sub-committee of the Council to Study JOURNAL

Operations composed of Drs. Marvin, Fincke and Gallivan with Dr. Marvin as chairman is to be congratulated on the job that it has done in an attempt to recommend to the Council a plan that will improve the JOURNAL as a whole with particular emphasis upon the preparation, selection, and editing of scientific articles and editorials. New amendments to the by-laws are on the agenda of this meeting which should help to achieve this objective.

I have had an active part and interest in two Conference Committees, one the Conference Committee with the American Legion, Department of Connecticut, and second, the Conference Committee with the Connecticut State Bar Association. As I have mentioned before the deliberations and discussions of the latter group should prove very fruitful.

The growth of the Emergency Call Plans in Connecticut is gratifying. Very shortly there will be total coverage for the entire State.

The doctors of Connecticut have responded well to the American Medical Education Foundation, and the number of contributors is steadily increasing. Let us hope that this continues until every physician gives something to the medical schools of the United States.

I believe that the quality of medical care in Connecticut is excellent and will continue to improve. With the fine leadership and good sense that exists in this Society I know we shall go forward to greater and better things in the years to come.

Respectfully submitted,  
George H. Gildersleeve, M.D.

#### REPORT OF THE EXECUTIVE SECRETARY

The secretary's report of membership is published in the agenda commencing on pages 11 and 12 and I would like to draw your attention to some details in it. The Society had a net gain of 55 members during the year 1953 and at the beginning of 1954 the total membership was 2,863, the greatest it has ever been. The largest net gain was in New Haven County, 24, and two county associations show a net loss during the year, Middlesex three and Tolland one. Forty members were lost by death during 1953 which figure is somewhat larger than in 1952 when it was thirty-one. Among the members who died last year were a number who had held important places in the Society including two past presidents, Dr. Joseph H. Howard and Dr. Samuel C. Harvey.

In the presence of the great wealth of reports which are before you, it may seem unnecessary for the secretary to add more. However, it is appropriate for me to express my appreciation of the activities and efforts of many members of the Society and others who have helped to make the past



year a successful one. The Council has been painstaking in its application to the Society's affairs and always patiently cooperative with the members demands.

Committee activities have increased during the year and many good things have been accomplished. Particular reference should be made to the diligence of the Committee on Mental Health in working for the final passage of legislation that created the State Commission on Mental Health already referred to by Dr. Danaher. This will be a lasting monument to the spirit of this committee and its chairman, Dr. DuBois. The Committee on National Legislation through its active and well informed chairman, Dr. Meeker, closely integrates the Society with affairs in Washington. The Committees on Industrial Health and Public Health and many others have discharged their duties with credit. The Connecticut Medical Examining Board which is also the Committee on Medical Education and Licensure of the Society has been faced with new and unique questions relating to the eligibility and recruitment of interns and residents for Connecticut hospitals. This committee drafted and put through the 1953 Legislature an amendment to the Medical Practice Act which liberalized the eligibility of graduates of foreign medical schools to extend their education in this State. This change in the law has made it possible for our hospitals to recruit interns and residents from the large pool of foreign graduates.

The committees working on this meeting, Program under the chairmanship of Dr. Nolan and the Local Committee on Arrangements under the chairmanship of Dr. Seigle, deserve your compliments. Arranging a meeting of this kind is not simple and when they receive the program and attend, many do not realize that the planning has been underway for a year. The technical exhibits in connection with our annual meetings increase in popularity among exhibitors and the income derived from them makes the meetings possible. I bespeak your interest in the technical exhibits and urge you to visit and make yourselves known to them all.

You have in your headquarters office a loyal and hard working staff. There have been some changes during the past year and these must, of course, be expected occasionally. I know you appreciate what these people do for you so cheerfully, efficiently. We need an additional secretary in the office because activities of the Public Relations section have increased to the point where it needs full time secretarial service and we shall make an effort to see that it is supplied within the present budget.

The state office continues in close and effective relationship with Mr. Gordon, executive secretary, and the office of the Hartford County Association and we note with interest the establishment of full time administration in Fairfield County and the appointment of Mr. Olson as executive secretary. We look forward to productive cooperation with him. Fairfield has invited the Society to meet in that county in 1955.

The Society has gained steadily in membership for many years. In 1934 there were 1,504 members, in 1944, 2,020, today there are 2,899 and we rank among the leading states in proportion of the number of physicians holding membership in the State Society. There are two factors that influence this increase in membership. First, the rapidly growing population in Connecticut with an increased number of

physicians and secondly, the Society itself and its usefulness to the profession and public in our State.

This Society cannot be separated from the social and political environment in which it is and it is worthwhile for a moment to view that environment as it relates to us. Connecticut is the most rapidly growing State in the northeast. During the census period from 1940 to 1950 its population increased by more than 19 per cent or two and a half times more rapidly than the country as a whole. At the same time our neighbors in New England were losing population. The projected population curve for the State from 1950 to 1960 shows another sharp rise so that by then it is estimated that our population will be two and a quarter million. During the first four and a half years of this decade the increase in population has accelerated even faster than had been forecast. These figures are of especial significance to medicine because with the increase in population will be demand for extension of many medical services, hospital beds, public health facilities and the entire program in which we are involved.

There may be some who feel that this period of growth and prosperity may come to a sudden halt and the increased number of persons in the State will become a detriment to it in a time of unemployment and recession. There should be no attempt in this report to analyze that possibility, but it can be asserted with reasonable safety that the wide coverage of our people by voluntary medical care insurance will provide a valuable cushion in the event of depression. Even in periods of unemployment, experience has shown that there is a reluctance to give up hospital and medical insurance.

Our Society must be continuously aware of these future challenges, and I wish to express to all of you my deep admiration for the time and thought you give to medical affairs and for the privilege of working with you in our common purpose.

Creighton Barker, M.D.

## MEMBERSHIP REPORT OF THE SECRETARY

### FAIRFIELD COUNTY

Membership—January 1, 1953.....	717
New Members .....	43
Less:	
Deaths .....	13
Resignations, transfer, non-payment dues, etc... 8	21
Net Gain .....	22
Membership—December 31, 1953.....	739

### HARTFORD COUNTY

Membership—January 1, 1953.....	865
New Members .....	37
Less:	
Deaths .....	13
Resignations, transfers, non-payment dues, etc...18	31
Net Gain .....	6
Membership—December 31, 1953.....	871

## LITCHFIELD COUNTY

Membership—January 1, 1953.....	120
New Members .....	5
Less:	
Deaths .....	2
Resignations, transfers, non-payment dues, etc... 1	3
	—
Net Gain .....	2
Membership—December 31, 1953.....	122

## MIDDLESEX COUNTY

Membership—January 1, 1953.....	97
New Members .....	3
Less:	
Deaths .....	2
Resignations, transfers, non-payment dues, etc... 4	6
	—
Net Loss .....	3
Membership—December 31, 1953.....	94

## NEW HAVEN COUNTY

Membership—January 1, 1953.....	778
New Members .....	50
Less:	
Deaths .....	8
Resignations, transfers, non-payment dues, etc...18	26
	—
Net Gain .....	24
Membership—December 31, 1953.....	802

## NEW LONDON COUNTY

Membership—January 1, 1953.....	155
New Members .....	10
Less:	
Deaths .....	0
Resignations, transfers, non-payment dues, etc... 6	6
	—
Net Gain .....	4
Membership—December 31, 1953.....	159

## TOLLAND COUNTY

Membership—January 1, 1953.....	16
New Members .....	0
Less:	
Deaths .....	0
Resignations, transfers, non-payment dues, etc... 1	1
	—
Net Loss .....	1
Membership—December 31, 1953.....	15

## WINDHAM COUNTY

Membership—January 1, 1953.....	60
New Members .....	4
Less:	
Deaths .....	2
Resignations, transfers, non-payment dues, etc... 1	3
	—
Net Gain .....	1
Membership—December 31, 1953.....	61

## ASSOCIATE MEMBERS

January 1, 1953.....	11
New Members .....	1
Resignations .....	1
Associate Members—December 31, 1953.....	11
Total Society Membership—January 1, 1953.....	2,808
New Members .....	152
	—
Total .....	2,960
Less:	
Deaths .....	40
Resignations, transfers, etc. ....	57
	97
TOTAL SOCIETY MEMBERSHIP—December 31, 1953.....	2,863
Net Gain for year.....	55

## TOTALS

Fairfield .....	739
Hartford .....	871
Litchfield .....	122
Middlesex .....	94
New Haven .....	802
New London .....	159
Tolland .....	15
Windham .....	61
	—
	2,863
Associate Members .....	11
	—

## REPORT OF THE TREASURER

The financial statements prepared by Seward and Monde, auditors for the Society, are printed in entirety in the agenda. These statements are respectfully submitted as the report of the treasurer with the following comments:

The financial status of the Society is sound and secure.

I shall refer to a few items under the Statement of Income and Surplus General Fund, page 34, column 2, top.

The gross income, \$69,489, is approximately \$1,170 above that of 1952.

The expenses, \$58,788, are about \$5,470 more than in 1952. Actually, these expenses are \$1,400 under the budget for these items for this year.

In 1952 the excess of expense over income for JOURNAL Operations was \$3,720. This year it was \$7,107, as shown. The difference was due entirely to an increase in manufacturing cost.

A year ago the net income was \$11,000 plus, as compared with \$3,593.

Out of surplus in 1953 came the air conditioner, about \$4,000, which is reflected as an increase in the asset account of the Building Fund. Also from surplus came the Scholarships, amounting to something over \$2,000.

The General Fund Surplus for this year was reduced by \$2,382. This fact is not cause for the sounding of a general alarm.

Frank H. Couch, M.D.



Seward and Monde  
Certified Public Accountants

205 Church Street  
New Haven 10, Connecticut

The Connecticut State Medical Society  
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1953 and the related statements of income and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence by methods and to the extent we deemed appropriate.

*General Fund:*

Cash in banks, which was reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

*Commercial accounts:*

The Second National Bank and Trust Company .....	\$ 4,505.73
The Second National Bank and Trust Company—Journal revolving fund....	3,600.00
The Second National Bank and Trust Company—Executive secretary revolving fund .....	3,500.00
The Second National Bank, Trust Department:	
Income cash account.....	8,919.67
Principal cash account.....	20.89
	<hr/> \$20,546.29

*Savings accounts:*

Connecticut Savings Bank of New Haven .....	\$12,229.31
National Savings Bank of New Haven .....	10,530.39
Chelsea Savings Bank of Norwich.....	10,273.81
	<hr/> 33,033.51
	\$53,579.80
Petty cash—Journal office.....	5.00
	<hr/>
Total .....	\$53,584.80

The Second National Bank of New Haven confirmed directly to us that as of December 31, 1953 they held the following securities as agent for the Treasurer of The Connecticut State Medical Society:

*United States Treasury Bonds:*

FACE VALUE	RATE AND MATURITY	BOOK VALUE	MARKET VALUE
\$7,000	2½ % 1969	\$6,795.73	\$6,846.88
5,000	2½ % 1970	5,000.00	4,878.13
3,000	2½ % 1971	2,979.11	2,908.13
2,000	2 % 1957	2,000.00	2,051.88

*Province of Canada Bonds:*

3,000 Province of New Brunswick S.F. Deb. 4½ % due December 1, 1970.....	2,943.60	3,112.50
3,000 Province of Nova Scotia 3½ % Deb. due March 15, 1964 .....	2,988.75	3,030.00

*Stock:*

50 shares Celanese Corp. of Amer. Ser. A 4½ % cum. preferred .....	5,181.25	3,400.00
Total .....	\$27,888.44	\$26,227.52

Dues receivable of \$1,112.50 are segregated by counties as follows:

COUNTY	AMOUNT
Fairfield .....	\$ 450.00
Middlesex .....	25.00
Litchfield .....	62.50
New London .....	75.00
Hartford .....	375.00
New Haven .....	125.00
Tolland .....	—
Windham .....	—
Total .....	<hr/> \$1,112.50

Accounts receivable—Journal of \$298.67 consists of 1953 advertising accounts which were paid in 1954.

Accounts payable—Journal of \$299.65 represents amounts due for printing expenses.

The following is a comparison of budgeted and actual general expenses:

	BUDGET	ACTUAL	ACTUAL OVER OR (UNDER BUDGET)
Secretary's office .....	\$29,110.32	\$28,090.09	(\$1,020.23)
Treasurer's office .....	2,770.00	2,483.91	( 286.09)
General and contingent .....	4,400.00	4,510.92	110.92
Public relations .....	13,854.00	12,876.50	( 977.50)
Committee allotments ..	3,375.00	2,569.40	( 805.60)
Building maintenance ....	7,935.00	8,258.12	323.12
Journal .....	32,354.00	33,601.31	1,247.31
Total .....	\$93,798.32	\$92,390.25	(\$1,408.07)

*Annual Meeting Fund:*

Cash of \$12,398.77 in the New Milford Savings Bank and a balance of \$50.98 in The Union and New Haven Trust Company was confirmed directly.

*Gordon W. Russell Fund:*

Cash of \$3,314.62 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

The Second National Bank of New Haven confirmed directly to us that as of December 31, 1953 they held the following fund securities as Agent for the Treasurer of the Connecticut State Medical Society:

	VALUE DECEMBER 31, 1953	PER BOOKS	MARKET
\$691.12 New York, New Haven and Hartford Railroad Co. 4%—due 2007.....	\$ 458.00	\$ 461.32	

\$985.61 New York, New Haven and Hartford Railroad Co. 4½%—due 2022.....	338.00	551.94
\$523.27 New York, New Haven and Hartford Railroad Co. 5%—Series A.....	134.00	272.10
\$1,000.00 Boston and Albany Railroad Company, 4¼% improvement bonds, due August 1, 1978.....	820.00	780.00
\$5,000.00 U. S. Treasury bonds, 2¼% due 1959 .....	5,000.00	5,006.25
Totals .....	\$6,750.00	\$7,071.61

*O. C. Smith Fund:*

We confirmed the principal and income cash of \$1,209.62 in the Mechanics Savings Bank, Hartford, by direct correspondence.

*Building Fund:*

An expenditure of \$3,932.39 out of general fund surplus for an air conditioning system has been added to the building equipment account. During the year funds have been transferred from the general funds to the reserve for depreciation. The cash so transferred was confirmed directly with the depository.

*Clinical Congress:*

Cash of \$3,466.32 in the New Haven Savings Bank and a balance of \$21.58 on deposit at The Second National Bank of New Haven was confirmed directly by the depositories.

The Secretary's office has acted as collection agent for The American Medical Association's dues and The American Medical Education Foundation for the year 1953. At December 31, 1953 all collections received to that date had been remitted to The American Medical Association.

In our opinion, the accompanying balance sheet and statements of income and surplus present fairly the position of The Connecticut State Medical Society at December 31, 1953, and the results of its operations for the year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Seward & Monde,  
Certified Public Accountants

New Haven, Connecticut  
March 4, 1954

## Balance Sheet, December 31, 1953

## GENERAL FUND

## ASSETS

Cash .....	\$53,584.80
Investments (market value \$26,227.52).....	27,888.44
Dues receivable—1953 .....	1,112.50
Accounts receivable—Journal advertising .....	298.67
Automobile emblems on hand.....	87.00
Prepaid insurance .....	650.10
Total .....	\$83,621.51

## LIABILITIES

Accounts payable:	
Journal .....	\$ 299.65
Accrued commissions—1953 dues.....	5.25
Surplus .....	83,316.61
Total .....	\$83,621.51

## ANNUAL MEETING FUND

## ASSETS

Cash .....	\$12,449.75
Prepaid expenses—1954 annual meeting....	152.72
Total .....	\$12,602.47

## LIABILITIES

Surplus .....	\$12,602.47
Total .....	\$12,602.47

## SPECIAL FUNDS

## ASSETS

## Gurdon W. Russell Fund:

Cash .....	\$ 3,314.62
Investments (market value \$7,071.61) .....	6,750.00
	\$ 10,064.62

## O. C. Smith Trust Fund:

Principal cash .....	\$ 1,000.00
Income cash .....	209.62
	1,209.62

## Building Fund:

Land .....	\$ 12,270.31
Building and equipment.....	81,253.57
	\$ 93,523.88
Cash—savings account (funded reserve for depreciation).....	5,831.76
	99,355.64

## Clinical Congress:

Cash .....	3,487.90
Total .....	\$114,117.78
Grand total .....	\$210,341.76

## LIABILITIES

Gurdon W. Russell Fund—capital.....	\$ 10,064.62
O. C. Smith Trust Fund—capital.....	1,209.62
Building Fund:	
Reserve for depreciation .....	\$ 5,831.76
Capital .....	93,523.88
	99,355.64
Clinical Congress—capital .....	3,487.90
Total .....	\$114,117.78
Grand total .....	\$210,341.76



## Statement of Income and Surplus

## General Fund

Year Ended December 31, 1953

## Income:

Dues earned .....	\$64,900.00
Less, Commissions paid .....	276.50
	<hr/> \$64,623.50
Interest and dividends on investments.....	1,714.77
Gain on sale of securities.....	163.50
Sale of automobile emblems.....	66.00
Rental income .....	2,365.13
Income from collection of AMA assessments.....	556.24
	<hr/>
Gross income .....	\$ 69,489.14

## Expenses:

Secretary's office .....	\$28,090.09
Treasurer's office .....	2,483.91
General .....	2,997.26
Contingent fund .....	1,513.66
Public relations .....	12,876.50
Committee allotments .....	2,569.40
Building maintenance .....	8,258.12
	<hr/> 58,788.94
Excess of general income over expenses.....	\$10,700.20
Less, Excess of expenses over income—Journal operations .....	7,107.15
	<hr/>
Net income .....	\$ 3,593.05
Surplus, January 1, 1953 .....	\$85,698.64
Less, Appropriations out of surplus:	
Installation of air condi- tioning system .....	\$3,932.39
Scholarships .....	2,042.69
	<hr/> 5,975.08
	<hr/> 79,723.56
Surplus, December 31, 1953.....	\$83,316.61

## Detail of Expenses

Year Ended December 31, 1953

## Secretary's Office:

## Personal Services:

Executive secretary .....	\$14,000.00
Annuity for executive secretary.....	999.94
Administrative assistant .....	4,500.00
Secretary .....	2,915.00
Secretary .....	2,004.00
Stenographer .....	1,084.32
	<hr/>
	\$25,503.26

## Less, Transferred to:

Treasurer's office .....	\$ 750.00
Public relations .....	1,200.00
Collection AMA dues.....	295.00
	<hr/> 2,245.00
	<hr/> \$23,258.26

Executive secretary expense .....	1,484.49
Executive secretary expense—prior years.....	710.32
Office supplies .....	216.53
Printing and postage.....	988.73
Automobile expense .....	721.04
Telephone and telegraph.....	290.37
Bank charges .....	21.38
Publications .....	44.79
Social security taxes.....	198.32
Miscellaneous .....	155.86
	<hr/>
Total .....	\$28,090.09

## Treasurer's Office:

Personal service .....	\$ 750.00
Auditors .....	570.00
Fiscal agent .....	368.71
Postage and printing—(collection of society dues)	275.44
Postage and printing (collection of AMA dues)	500.00
Miscellaneous .....	19.76
	<hr/>
Total .....	\$ 2,483.91

## General:

Chairman of council.....	\$ 300.00
President of society.....	300.00
Council .....	709.86
Delegates to AMA convention.....	1,168.75
Woman's Auxiliary .....	300.00
Blue Cross premium for employees.....	218.65
	<hr/>
Total .....	\$ 2,997.26

## Contingent Fund:

Connecticut Physicians Art Association.....	\$ 124.00
Conference of county officers.....	235.38
Connecticut Health League Dues.....	10.00
Semi-annual meeting—House of Delegates.....	299.30
Civil Defense Conference.....	62.99
Insurance questionnaire .....	263.27
Bar Association—joint meeting.....	94.38
Committee on Maternal Mortality.....	200.00
Staff expense—AMA Meeting.....	138.42
Miscellaneous .....	85.92
	<hr/>
Total .....	\$ 1,513.66

## Public relations:

Personal services—director .....	\$ 8,000.00
Printing and postage.....	\$ 946.86
Publications .....	162.95
Clipping service .....	228.00
Telephone and telegraph.....	172.10
AMA Educational Campaign.....	501.48
Travel and expense.....	525.19
Meetings of Public Relations Commit- tee .....	202.63
Clerical assistance .....	1,200.00
Health Exhibits—County Fairs.....	713.88
Supplies and miscellaneous.....	169.41
Social security taxes.....	54.00
	<hr/> 4,876.50
Total .....	\$12,876.50

*Committee Allotments:*

Public health .....	\$ 329.07
National legislation .....	37.75
Industrial health .....	162.57
Pharmaceutical—joint expense .....	126.50
Medical care veterans.....	407.35
Council of New England State Medical Societies .....	269.69
Emergency medical service.....	.69
Rural health .....	27.72
Advisory—physician draft .....	—
Mental health .....	126.45
Cancer coordinating committee.....	33.46
Coop. committee—Yale .....	144.36
Food, drugs, cosmetics, and devices.....	119.32
Honorary members .....	17.75
Hospital committee .....	25.20
Medical education and licensure.....	299.11
Professional relations .....	28.12
Conference of Presidents.....	75.00
Foundation of Economic Education.....	100.00
State Legislation .....	200.12
Third Party payments.....	39.17
<b>Total .....</b>	<b>\$ 2,569.40</b>

*Building:*

Taxes .....	\$ 1,737.02
Janitor .....	960.00
Insurance .....	378.04
Electricity, gas and water.....	653.87
Fuel .....	467.97
Care of grounds.....	507.11
Depreciation and obsolescence.....	1,400.00
Supplies .....	223.96
Telephone .....	896.28
Repairs and replacements .....	1,033.87
<b>Total .....</b>	<b>\$ 8,258.12</b>

### Statement of Journal Operations Year Ended December 31, 1953

*Income:*

Advertising (net of commissions).....	\$22,330.12
Subscriptions .....	1,019.24
Reprints .....	2,846.66
Electrotypes .....	154.54
Single copy .....	35.94
Roster book .....	83.00
Miscellaneous .....	24.66
<b>.....</b>	<b>\$26,494.16</b>

*Expenses:*

<i>Personal services:</i>	
Editor-in-chief .....	\$2,000.00
Literary editor .....	2,000.00
Secretary .....	2,806.00
Advertising agent .....	240.62
<b>.....</b>	<b>\$ 7,046.62</b>

*Manufacturing cost:*

Printing .....	\$22,818.21
Postage and handling .....	538.06
Electrotypes .....	932.88
Reprints .....	1,578.90
<b>.....</b>	<b>25,868.05</b>

*Other:*

Telephone .....	\$ 61.30
Office expense .....	163.91
Sales tax .....	26.53
Clerical assistance .....	66.00
Editorial Board meetings.....	15.30
Treasurer's honorarium .....	100.00
Social security taxes.....	101.34
Publications .....	27.50
Miscellaneous .....	124.76
<b>.....</b>	<b>686.64</b>
<b>.....</b>	<b>33,601.31</b>
Excess of expenses over income.....	\$ 7,107.15

### Statement of Income and Surplus Annual Meeting Fund Year Ended December 31, 1953

*Income:*

Exhibits .....	\$ 7,800.00
----------------	-------------

*Expenses:*

Program Committee and local Committee on arrangements .....	\$ 110.49
Telephone .....	56.05
School rental and janitor service.....	551.75
Printing and postage.....	1,446.84
Art exhibit .....	50.00
Exhibit decorator, rentals and equipment .....	1,164.05
Meeting operating expenses.....	137.28
House of Delegates Ann. Mtg. ....	467.25
Lunches and dinner expense (guests and entertainment) .....	454.45
Extra help, clerical, police, projectionist .....	482.51
Speakers and visiting delegates.....	335.81
Council dinner .....	352.83
Miscellaneous .....	13.61
<b>.....</b>	<b>5,622.92</b>

Excess of meeting income over meeting expenses .....	2,177.08
Surplus, January 1, 1953.....	\$10,115.28
Add, Interest earned on savings account .....	310.11
<b>.....</b>	<b>10,425.39</b>
Surplus, December 31, 1953.....	\$12,602.47

### Statement of Capital Special Funds

## Year Ended December 31, 1953

## GURDON W. RUSSELL FUND

Balance, January 1, 1953.....	\$10,268.49
Add, Interest and dividends on savings accounts and bonds .....	332.44
Proceeds from sale of equipment.....	40.00
<b>.....</b>	<b>\$10,640.93</b>



Deduct, Disbursements for sundry items of equipment and furniture.....	576.31
Balance, December 31, 1953.....	\$10,064.62

## O. C. SMITH FUND

Balance, January 1, 1953.....	\$ 1,306.47
Add, Interest received on savings accounts.....	28.15
	\$ 1,334.62
Deduct, Dues paid.....	125.00
Balance, December 31, 1953.....	\$ 1,209.62

## BUILDING FUND

Balance, January 1, 1953.....	\$89,778.82
Add, Installation of air conditioning system contributed from general fund surplus.....	3,932.39
	\$93,711.21
Deduct, Expenses of supplies and maintenance not capitalized .....	187.33
Balance, December 31, 1953.....	\$93,523.88

## BUILDING FUND—RESERVE FOR DEPRECIATION

Balance, January 1, 1953.....	\$ 4,315.05
Add, Interest earned.....	116.71
Transfer from general funds.....	1,400.00
Balance, December 31, 1953.....	\$ 5,831.76

Statement of Income and Capital  
Clinical Congress Fund  
Year Ended December 31, 1953

*Income:*

Registrations .....	\$ 1,510.00
---------------------	-------------

*Expenses:*

Committee meetings .....	\$ 113.55
Luncheons—net of receipts.....	—
Speakers .....	828.89
Badges .....	19.50
Telephone .....	17.56
Printing and postage.....	575.16
Rentals .....	189.69
Clerical assistance .....	55.00
Miscellaneous .....	8.19
	1,807.54

Excess of expenses over income.....	\$ 297.54
Surplus, January 1, 1953.....	\$ 3,698.92
Add, Interest earned on savings account .....	86.52
	3,785.44
Surplus, December 31, 1953.....	\$ 3,487.90

REPORT OF EDITOR-IN-CHIEF OF  
CONNECTICUT STATE MEDICAL JOURNAL

Stanley B. Weld, *Chairman*

Frank S. Jones

Clair Rankin

Marshall C. Pease

Herbert Thoms

The year 1953 has produced 48 scientific articles, 40 by members of the Society and 8 by nonmembers. This represents about the usual number in this category. Articles not truly scientific but definitely medical in their content numbered 33, of which 17 were by members and 16 by nonmembers. Thus we find our JOURNAL carried 81 medical articles during the past year.

The section entitled Progress in Clinical Medicine appeared in almost every issue, there being 18 articles in all, 17 of which were by members. Nine of these appeared in one issue when a symposium on glaucoma was published.

The Historian's Note Book did not fare as well since it appeared in only 4 issues, each article by a different member-author of our Society.

In 1952 we published 83 editorials and during the past year 78. These dealt with scientific, socio-economic, and public health problems. They were written for the most part by the secretary of the Society, the literary editor, the editor-in-chief, and by G.B., a loyal member living in California.

The president of the Society in his President's Page has carried out his function faithfully, that of bringing to the attention of our readers pertinent issues of the Society and of medicine in general.

Five letters to the Editor have been published, not a large number but again, as mentioned in a previous report, probably evidence of the hesitancy of our readers to express themselves in a critical manner. Obituaries of 18 deceased members were published and there appeared during the year 33 book reviews.

The advertising for 1953 continued to bring in the necessary revenue. The State Journal Advertising Bureau in Chicago had a very successful year and our JOURNAL shared proportionately in the profits. Our local advertising representative is gradually increasing his effectiveness, thus making his value to our JOURNAL a real one.

One innovation has been introduced this past year, that of placing a short summary of each article at the beginning. This corresponds to the blurb found in lay publications and from the responses which have come to the editor seems to be appreciated, especially with our readers who find their time limited.

One special number, the Convention Issue, appeared early in April and carried, in addition to the complete program of the annual State Society meeting and the programs of the annual County Association meetings, pictures of the speakers at the State meeting and of the Hamden High School, "An Account of Old Hamden circa 1836," an historical article on "Early Days of the New Haven Medical Association" by one of our members, and descriptive article on "Portraits of Doctor Hezekiah Beardsley and His

Wife, Elizabeth" by the librarian of the Yale Medical Library.

The work of the editor has been increased by the illness of Dr. Thoms, the literary editor. Dr. Barker, secretary of the Society, has kindly assumed some of the responsibilities of securing manuscripts and has written many of the editorials, making the work of the editor that much easier. Dr. Pease has continued to carry on the arduous task of abstracting articles from our exchange journals and both Drs. Brackett and Blumer are showing an increasing interest in supplying material for The Historian's Note Book. Dr. Clair Rankin has been of valuable assistance in keeping Progress in Clinical Medicine supplied with material and Dr. Hugh Caven at the Institute of Living has generously furnished editorial assistance.

Mrs. Vivian Feriola has continued to fill her role as office secretary in a most satisfactory manner, attending to the many details of advertising contracts, copy and billing, to the subscription lists, and to the endless correspondence which is involved in a busy office. She continues to be of invaluable assistance to the editor.

We are convinced now that our members read the JOURNAL. Many comments are received by mail and by word of mouth attesting to the interest found in some part of the JOURNAL. All this makes the editor's life more satisfying.

Respectfully submitted,  
Stanley B. Weld

REPORT OF THE SUB-COMMITTEE ON  
SCHOOL HEALTH

Charles A. Murphy, *Chairman*

Ira D. Beebe, D.D.S.	Leonard Parente
Mr. Finis Engleman	J. Harold Root, Sr.
Joseph L. Hetzel	James H. Root, Jr.
Stanley H. Osborn	Charles C. Wilson

This Committee was organized in June of 1952 as a sub-committee of the Committee on Public Health.

Meetings have been held each month since its organization.

All phases of school health have been discussed during these meetings. At a recent Public Health meeting approval was obtained of the Sub-Committee's plan to organize a State School Health Council under the joint sponsorship of the Departments of Health and Education. The first meeting of this Council occurred in February of this year. It is anticipated that many of Connecticut's school health problems may be discussed and policies formulated at subsequent meetings of this Council.

Respectfully submitted,  
Charles A. Murphy

REPORT OF COMMITTEE ON PROFESSIONAL  
RELATIONS

William H. McMahon, *Chairman*

Albert M. DeTora	Israel S. Otis
Ralph L. Gilman	Frank L. Polito
Harold W. Higgins	William J. Tate
William H. Upson	

During the past year, four cases have been referred to the Committee on Professional Relations. The complaints have been based on the premise of over-charging on the part of the attending physician or complaints of service or treatment.

The complaints as presented were completely aired at a hearing in which the complainant was asked to be present to personally state his complaint. It is the policy of the committee to refuse to act on any complaint in the absence of the plaintiff.

Case No. 1.

This case, from Fairfield County, was one in which the complainant accused the doctor of refusing to treat a patient whom he had previously examined. The charge was not brought to light until two years after the alleged refusal of the doctor to respond to the call. The physician's explanation was heard and was satisfactory to the committee. The complainant did not appear and the doctor was exonerated.

Case No. 2.

This case, from New London County, was a complaint of an excessive fee. Previous to the charge of excessive fee, the executors of an estate had already made a settlement of the claim and the case was satisfactorily closed. Following the settlement, a third party brought the complaint of overcharge. The complainant was invited to meet with the Professional Relations Committee, an invitation which was not accepted. The defendant physician was present and after hearing his testimony, he was exonerated.

Case No. 3.

This case from New London County resulted from the plaintiff's charge that burns on her foot were improperly treated. Her claim stated that as a result of the improper first treatment she had to undergo surgery. This woman was present at the hearing of our committee. Her testimony was of a rambling nature, involving several physicians. After a prolonged hearing, the doctor was exonerated.

Case No. 4.

This case from New Haven County, was a charge of excessive fee. Both plaintiff and defendant presented testimony and after due deliberation of the committee it was decided unanimously that the physician's charges were excessive and the decision of the New Haven County Board of Censors was not upheld. Since this meeting, the defending physician has appealed our decision to the Council for review. The Council approved the decision of this Committee.

Respectfully submitted,  
William H. McMahon



## REPORT OF THE COMMITTEE ON POSTGRADUATE EDUCATION

Hugh L. Dwyer, *Chairman*

Bliss B. Clark	Marvin Lillian
Richard B. Elgossin	Robert M. Lowman
Malcolm M. Ellison	Benjamin E. Lyons
William J. Lahey	A. Rocke Robertson
Charles Russman	

The activities of this Committee over the past year have been limited to the planning of the annual Connecticut Clinical Congress, as in the recent past. The program for the 1953 Clinical Congress was planned and executed largely by Drs. Hugh Dwyer, Creighton Barker, and Dean Vernon W. Lippard, with considerable assistance from various members of the State Society who gave helpful suggestions in the composition of the program. The pattern established in 1952 was repeated, and all of the sessions were held at the Yale University School of Medicine and the New Haven Unit of the Grace-New Haven Community Hospital. The Congress was in session for two days, and the plan established the previous year of having three programs going forward simultaneously in the Medical School Amphitheaters and Auditoria was followed. The Congress had a wide appeal and, despite the fact that the more popular parts of the program having the greatest appeal were held in the largest available amphitheater, there was overcrowding on several occasions. Four hundred and fourteen members of the Society registered for all or part of the Congress and sixty-seven non-member physicians registered as well. As has been true in the past, a large number of medical students, interns, and residents as well as a few other guests attended the clinical sessions, numbering two hundred and fifty-five, for a total registration of seven hundred and thirty-six. There was a total paid registration of four hundred and eighty-one. The figures fell a little short of the registration on the previous year and again a small deficit of \$297.55 resulted. Despite this, all verbal reports received by the members of this Committee were favorable with few exceptions and the latter, for the most part, had to do with over-crowding on a few occasions in the largest of our available auditoria. The success of a two-day Clinical Congress, with all of the sessions held in the Medical School, seems to have been established to the satisfaction of all. Plans are now beginning for the 1954 Clinical Congress which is to be held on September 14 and 15.

In recent years the limitation of the activities of this Committee to the Clinical Congress has led to infrequent participation of the entire Committee. There is evidence of a renewed interest in widening the activities of this Committee in the field of Postgraduate Education beyond that of the Clinical Congress alone, and it seems likely that the scope of the activities this Committee should and will increase, requiring more active participation of all the members.

Respectfully submitted,  
Hugh L. Dwyer

## REPORT OF COMMITTEE ON INDUSTRIAL HEALTH

Preston N. Barton, *Chairman*

Harold A. Bergendahl	Milton F. Little
J. Edward Canby	J. Wister Meigs
George H. Carter	Philip J. Moorad
Bernard S. Dignam	Frank T. Oberg
Harry S. Frank	Andrew W. Orlowski
John N. Gallivan	Israel S. Otis
Albert S. Gray	Harold P. Stetson
Richard J. Hinchey	Paul W. Vestal
Andrew J. Jackson	Ellwood C. Weise
John F. Kilgus	Harold W. Wellington
Thomas F. V. LaPorte	J. Alfred Wilson
Daniel F. Levy	C. Frederick Yeager

During the past year the Committee on Industrial Health has held seven meetings, four being Executive Board meetings and three being meetings of the Full Committee.

In the Spring of 1953, the Section on Occupational Health of Yale University, Department of Public Health, jointly sponsored with this Committee, the presentation of an eight weeks' course in Occupational Medicine to the Litchfield County Chapter of the American Academy of General Practice. This program, which was well received, was carried out in line with the recommendations of the Joint Committee on Education of the American Academy of General Practice and the Council on Industrial Health of the American Medical Association. Those attending received 16 hours post-graduate credit with the Academy. It is the feeling of this Committee that similar programs, in other areas of the state, could be promoted to good advantage to the physicians who may have some part-time or on-call industrial affiliations.

Efforts have been made during this year to stimulate greater activity on the part of the Committees on Industrial Health of the County Medical Societies. A letter was addressed to these committees in September indicating that we felt if county committees were able to constructively promote industrial health programs in industry, it would result in a general improvement in all matters pertaining to group disability insurance administration, including the relationships between the carriers and the physicians. It is our understanding that there are studies and discussions underway in some of the counties toward a fuller exploration of this general subject at the local levels.

On September 23, sponsored jointly by the Gaylord Farm Sanatorium and this Committee, a Symposium was presented on the Modern Trends in the Management of Tuberculosis. Invitations were issued to all members of the Society and this meeting was well attended.

Ten years ago, with the active participation of this Committee, a program was introduced at Yale University School of Medicine in Occupational Health. Funds were obtained principally from industry which have carried this program to the present date. These funds are now exhausted. Much of the activity of the Committee this year has been a co-operative endeavor with Yale in the traditions of the rela-

tionships of this Society and the University. Although much has been accomplished in the teaching of Occupational Medicine and Occupational Health at Yale over the last seven years, with the increasing developments in the field of occupational medicine it appears that in the future a more active and comprehensive program is desirable. Without such a program of teaching in the medical schools of this country, it is doubtful that medicine will be able to meet the estimated needs and demands that are developing in industry for industrial medical services. Therefore, an objective of this Committee has been to work with the Dean of the School of Medicine and the Chairman of the Department of Public Health toward outlining a program of teaching and services which would have reasonable prospect of fulfilling the needs of the immediate future. The program as now proposed would be comparable to that which is now offered in the few schools of medicine in this country that have developed comprehensive facilities and talents in this area of medical interest. Wherever members of this Society can give active assistance in the furthering of this program, it is our opinion that they will be serving medicine in general.

During the past year, the Chairman of the Committee on Industrial Health has been privileged to serve on the committee appointed by the AMA Council on Industrial Health to draw up an outline of "Guiding Principles for Physicians in Industry." This document which will be presented to the House of Delegates of the AMA, contains much of the material which your Society acted upon favorably at its last annual meeting when it adopted the Code of Ethics Relating to Occupational Medicine and stands as another example of the leadership this Society has held over the years. It may be of interest to the members of the Society that since your favorable action last year on this Code of Ethics Relating to Occupational Medicine there has been a notable reduction in the frequency of misunderstandings and complaints that have come to the attention of the Committee. There is no question but what its use and application has been desirable and constructive.

Respectfully submitted,  
Preston N. Barton

## REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

### CONNECTICUT MEDICAL EXAMINING BOARD FOR THE CALENDAR YEAR 1953

John D. Booth, President

John B. Bumstead	Louis P. Hastings
C. Louis Fincke	Carl E. Johnson

Crichton Barker, Secretary to the Board

The Connecticut Medical Examining Board is the Society's Committee on Medical Education and Licensure and this report of the Committee is the official report of the Medical Examining Board.

The Board lost a valued member and the committee also when Dr. Wilmot C. Townsend died on May eleventh. Dr. Townsend was first appointed to the Board

on January 1, 1947 and during his years of service contributed richly through his judgment and understanding of high professional qualification. On recommendation by the President of this Society, according to law, Governor Lodge appointed Dr. C. Louis Fincke to succeed Dr. Townsend.

The Board has had six regular meetings during 1953 as required by the Medical Practice Act and three special meetings. Charges against one Connecticut physician were brought by the State Department of Health and the Board held hearings in this case.

The rapidly increasing number of foreign physicians coming to America and Americans who are graduates of foreign medical schools present a problem to all state medical examining boards. Some of them answer by simply declining to admit any graduates of schools outside of the United States. This is not the policy in Connecticut, and located as it is on the prosperous eastern seaboard and adjacent to the greatest port of entry, it is to be expected that many of these physicians from foreign lands would wish to come here. Currently, the Board receives about twenty-five inquiries each month from foreign medical graduates which is approximately one-half as many inquiries as are received from graduates of American medical schools. There are many pressures exerted on the Board to liberalize its regulations concerning foreign graduates, even though Connecticut is recognized as being among the more liberal states. It has lately been said by Willard Rappleye, Dean of Medicine at Columbia University, that "a double standard of medical qualifications is rapidly developing in this country, on the one hand, is the high standard set by American medical education; and on the other, the uncertain quality of foreign training." He likens it to the circumstances that prevailed here fifty years ago when there was a large number of inferior proprietary medical schools turning out incompletely trained physicians. Connecticut must face this problem fairly and clearly and not awaken twenty to twenty-five years from now in the realization that the quality of medical service has deteriorated.

Two hundred and seventy-three persons were certified as eligible for licensure. The methods of obtaining such certifications were as follows: one hundred and eighty-three presented certificates issued by the National Board of Medical Examiners; sixty-one presented acceptable licenses issued by twenty-four states and twenty-nine were certified on the basis of written examinations. Forty-two individuals took the licensing examinations fifty-five times. Twenty-seven of these candidates were successful and twenty-eight of the fifty-five examinations were failed.

The states represented by the presentation of credentials were: New York 15; Maryland 6; Massachusetts 4; California 3; Pennsylvania 3; Virginia 3; Georgia 2; Kentucky 2; Maine 2; Michigan 2; Minnesota 2; Ohio 2; Tennessee 2; Texas 2; District of Columbia, Florida, Illinois, Iowa, Louisiana, Missouri, New Hampshire, New Jersey, South Carolina and Vermont one each.

Three of the failures were graduates of three American Medical schools. Twenty-eight of the 42 candidates, graduates of 18 medical schools located out-side of the United States and Canada, took the examinations 41 times. Of these 28 candidates, 16 finally passed, a failure rate of 43%. The schools represented and the number of candidates from each



were: Albert Ludwigs University, Freiburg (1); Georg August University, Göttingen (1); University of Rome, Italy (1); University of Naples, Italy (1); University of Oslo, Norway (1); University of Amsterdam, Netherlands (2); University of Budapest, Hungary (6); University of Glasgow (1); Christian Albrechts University, Kiel (1); American University of Beirut (2); University of Habana (1); University of Lausanne, Switzerland (2); University of Vienna (2); University of Geneva (1); University of Paris (1); Charles University, Prague (2); Hsiang Ya, China (1); Karl Franzens University, Graz, Austria (1).

The schools that provided the greater number of graduates during 1953 were:

Yale .....	22	Vermont .....	8
New York Medical.....	21	Hopkins .....	7
New York University..	16	Temple .....	6
Harvard .....	14	Georgetown .....	5
Tufts .....	13	Pennsylvania .....	5
Columbia .....	11	Albany .....	4
Cornell .....	11	Buffalo .....	4
Long Island .....	9	Rochester .....	4
Boston University .....	8	Vienna .....	4

Forty-five other schools were presented by three or less.

Connecticut law allows a registered osteopath to appear before the Medical Examining Board and take the examinations in medicine and/or surgery; and if successful in either or both, he is given a full license to practice medicine and/or surgery in addition to osteopathy. Three osteopaths availed themselves of this privilege. Three took the examinations in medicine and none were successful; one took the examination in surgery and was successful.

The General Statutes of Connecticut, supplemented by an interpretation by the Attorney General, have for years provided that only physicians eligible for a license to practice in this State to serve as interns or residents in Connecticut hospitals. The law did not require that these house staff members in fact be licensed, but they had to be eligible for licensure. This provision came into the Connecticut law during the days of sub-standard medical schools and when there were enough medical graduates to satisfy the demand for interns. The circumstances are different now. There are twice as many internships available each year than there are medical graduates and many hospitals have found themselves without any house staff, or at least limited in numbers, and hospitals in Connecticut are no exception to this; and many of them wish to recruit interns from the great pool of foreign graduates. There was criticism of the restrictions in the Connecticut law from some sources and the Board found itself in the unhappy position of being accused of keeping hospitals from obtaining interns. A solution to the dilemma was sought and finally, and it appears wise, an amendment to the Medical Practice Act was proposed which would allow the Connecticut Medical Examining Board to issue Educational Permits to physicians ineligible for licensure, to extend their education by internship and residency in Connecticut hospitals. This law was passed by the 1953 General Assembly and it is Section 1657c of the General Statutes. It became effective on May 21, 1953, and since that time fifty-two permits have been issued. It is too soon to state just what the experience will be, but so

far, it appears to have been successful. Two things have been accomplished, the physicians who have received these permits have been given the opportunity to take advantage of the educational programs offered in Connecticut hospitals and there are fifty or more interns and residents in Connecticut hospitals than there would have been if the law had not been changed. This must be helpful to hospitals that have had difficulties in obtaining interns. Currently, approximately fifty percent of the interns and the residents in Connecticut are graduates of medical schools outside the United States.

Respectfully submitted,  
John D. Booth

## REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Robert R. Keeney, Jr., *Chairman*

Clement F. Batelli	Clifford Joseph
John W. Buckley	Charles A. Murphy
Henry Bunting	Luther K. Musselman
Alfred L. Burgdorf	J. Harold Root
Francis H. Burke	Edward T. Wakeman
Clair B. Crampton	William A. Wilson
Frederick W. Goodrich	F. Lee Mickle—
William S. Maurer	<i>Associate Member</i>

The meetings of the Committee were held monthly and the attendance was good and many interesting problems were discussed during the course of the year. During the year several members of the Committee resigned and new members were reappointed to take their places. Late in the course of this year, Dr. Hubert of Torrington died and the Committee expressed their regrets at this unfortunate occasion to the family and remembers only too well the important work and the important contributions made to this Committee by Dr. Hubert in the past.

Several committee reports were made by Dr. Murphy who is the Chairman of the Committee on school health. This Committee functioned very actively during the year and finally brought in a recommendation of a Connecticut Advisory Council on school health.

A sum of \$250 was allocated to the sub-committee on laboratory studies to continue work in this field in the coming year.

The Committee recommended the approval of the plan for distribution of gamma globulin for use in poliomyelitis, nephrosis and measles in the first trimester of pregnancy and for infectious hepatitis. This program was used throughout the ensuing year and very little difficulty was encountered with distribution of the gamma globulin.

The Committee, also, studied and revised "Suggested Standing Orders and Policies for Public Health Nurses." This booklet was first put out in 1948 and after considerable study and discussion, many revisions were made in the outlines and a completely new book brought out which will be distributed by the Connecticut State Department of Health early in 1954.

Drs. Wakeman and Batelli functioned as the sub-committee on First Aid and made many important contributions in this field and worked in close conjunction with the State

Medical Society, The Women's Auxiliary and the State Department of Health. Many new pamphlets and posters were brought out during the course of the year. This Committee also functioned in presenting a pamphlet, "Home Accident Prevention—A Guide for Health Workers." The sub-committee and the Committee on Public Health has recommended that the matter of home accidents and accident prevention become a matter of vital interest to every physician in the Connecticut Medical Society and it is hoped that further emphasis along these lines in accident prevention may bring out a well coordinated program in this field in the near future.

Dr. Wilson brought up the question of "Voluntary Euthanasia Society of Conn." The Committee requested the Society to send the physician of their group to talk with us but this was not done and the Committee did not go into this problem at all during its meetings this year.

The leaflet "A Daily Food Diet for Expectant Mothers," which was prepared with the approval of the Committee on Public Health of the Connecticut State Medical Society, 1948 was revised in 1953 with many new suggestions and changes. The new, revised "A Daily Food Diet for Expectant Mothers" was approved by the council later this year.

The Committee on Public Health recommended approval of all the recommendations made by the Committee to Study Maternal Mortality and Morbidity concerning classification of a "Separate Unit" as found in the Sanitary Code Regulation 200B. Section A, Section B, Section E-2. Section A was changed as follows: "Any complication of pregnancy (including pyelitis of pregnancy) regardless of duration of pregnancy, may best be admitted to the obstetrical unit unless considered infected or potentially infectious. Only patients who are pregnant shall be admitted to the obstetrical unit. Incomplete abortion shall be considered potentially infected and are not to be admitted to the obstetrical unit. When a second condition, unrelated to the pregnancy itself exists, the decision as to ultimate disposition should rest with the Chief of Obstetrics and the Chief of the other service involved or their respective representatives." Section B of this recommendation was, after lengthy discussion, finally agreed to as follows:—Section (e) (2) A Separate Unit—"To insure the complete segregation of the maternity patients and newborn infants from other types of patients, a maternity hospital operated as part of a general hospital must be in a separate unit of the general hospital. Special provision shall be made to segregate the unit operationally to prevent the introduction of infection from other parts of the hospital and from the outside. It must have complete facilities for the care of maternity patients and newborn infants within the unit and either have its own separate sterilization equipment and sterile supplies or be furnished with sterile supplies from a central sterilizing room."

The Committee recommended to the council that the State Department of Health be given permission to participate with the National Foundation for Poliomyelitis in mass vaccination against poliomyelitis. This biggest experiment in U.S. Medical History will take place during the next few months, when, at least 500,000 children will be injected with a vaccine against poliomyelitis and will continue into June. Then, local medical teams under the Na-

tional Foundation for Infantile Paralysis and the State Departments of Health will wait and watch as the annual curve of polio begins to climb, slowly in June, higher in July, highest in August and September, then falls again with cool weather. Comparing the amount of polio among the inoculated children with that among the uninoculated ones, a committee of leading scientists will be able to judge the vaccine's effectiveness. In theory it should produce immunity against polio in most or all of the inoculated children. The expectation is that it will produce, at least, some. Conceivably, it may produce none.

The Chairman of this Committee wishes to thank all members of the Committee for their willingness to work and their participation in all of the problems taken up this past year. It has been a privilege for me to be a member of this Committee.

Respectfully submitted,  
Robert R. Keeney, Jr.

**CRIPPLED CHILDREN TECHNICAL MEDICAL  
ADVISORY COMMITTEE**

Edward T. Wakeman, *Chairman*

Norton Canfield	Edward J. Ottenheimer
Burr H. Curtis	William M. Shepard
David Gaberman	Robert P. Rogers
Denis S. O'Connor	C. Norton Warner, Jr.

Herman Yannet

This is a subcommittee of the Committee on Public Health of the Connecticut State Medical Society.

Two meetings were held in 1953, one April 6 and one November 24.

1. At the April 6 meeting the committee considered the appointment of orthopedic surgeons to replace Dr. Charles Goff, consultant to the Norwich clinic for 4 years and Dr. Maurice Pike, consultant to the Torrington clinic for 12 years. These two men have given valuable services to crippled children over these years. It was with regret that both surgeons resigned due to pressure of other work.

The committee recommended that Dr. Edward Crosby be appointed consultant to the Norwich clinic and Dr. Victor Conforti to the Torrington clinic. The committee suggested a letter of appreciation be sent to Dr. Pike and Dr. Goff.

Other consultants to the division of crippled children were reappointed for the year beginning July 1, 1953.

2. The committee reviewed the survey "Connecticut People and Their Hearing. A Survey and Study" which was prepared for the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology. The recommendations of the survey were related to the hearing conservation program conducted by the Division of Crippled Children. It was recommended that additional funds could be used in those areas where clinic facilities are available. If not available, they might be established if possible. Areas suggested to extend the hearing services are southwestern and northeastern Connecticut. At the time this meeting was held services were available primarily in northern Connecticut through the hearing conservation clinic in Hartford.



Children who have hearing loss, cleft palate, are eligible for speech services. Children with so-called functional speech defects are not because the speech therapists are too busy with the other types. It has been found on several occasions that some of these children with so-called functional speech defects had severe hearing loss. In order that such children not be missed, it was recommended that every child with speech defect who is referred should have a hearing test to determine whether the defective speech is due to loss of hearing.

4. It was reported to the technical medical advisory committee that the Committee on Public Health at its March meeting had approved the inclusion of nephrosis under the state crippled children program. It was also reported at the meeting that the crippled children law, as it now stands, would not have to be amended to include nephrosis since it is a permissive law.

At the November 24 meeting these items were discussed:

1. It was with regret that the committee learned that Dr. Edward Crosby who had been appointed consultant to the Norwich clinic in May had died in September. The committee recommended that Dr. Andrew Thomas of Manchester be appointed to replace Dr. Crosby.

The committee suggested that a letter of sympathy be sent to Mrs. Crosby expressing our deep sense of loss and our appreciation of his devoted services to crippled children. The committee also expressed appreciation to Dr. Goff for filling in at the Norwich clinic until Dr. Crosby's successor could be appointed.

2. The subject of aphasia was discussed. It was recommended that children with aphasia who can be rehabilitated be accepted on the crippled children program. Wherever possible the speech therapists in public schools and private speech teachers would be utilized and where facilities are not available they will be treated by the speech therapists on the staff of the division of crippled children.

3. Due to the interest of the Connecticut Chapter of the National Hemophilia Foundation the subject of hemophilia was discussed. Children with hemophilia are accepted for care under the state crippled children program when they have orthopedic complications, but not during an acute bleeding episode. The committee recognizes that the prevention of crippling conditions is a function of the crippled children program and therefore the prevention of crippling from hemophilia.

The committee recommended that those children who cannot otherwise be provided hospital care for dangerous bleeding should be assisted by the division of crippled children. However, such a program would take funds away from the existing crippled children activities. When additional funds are available, services to children with hemophilia, as noted, can be provided.

It was pointed out that perhaps some physicians do not know about the use of fresh, frozen plasma or about the seven depots from which plasma can be obtained. It was thought advisable to carry on an educational program for physicians on the subject of hemophilia as it is now being done on nephrosis.

4. The subject of muscular dystrophy was discussed, particularly from the point of view of value of follow-up care of these patients who represent a group of patients with chronic or handicapping ailments even though the outcome may be fatal. Various members of the committee stated that much can be done for children with muscular dystrophy, both from the physical point of view as well as the educational and social.

It is believed that children can be kept ambulatory longer and of more use to themselves for a longer period of time when they receive physical therapy and other methods of orthopedic treatment. The value of support given to the families and the children by physicians and allied health workers was emphasized. This support is primarily in the nature of advice to parents and a showing of interest. Most of the physical therapy treatments can be given by the family with periodic supervision by a therapist.

There was some comment as to the value of carrying on an educational program for physicians on muscular dystrophy similar to that on nephrosis.

There was some discussion on the need for coordination of the activities of the various voluntary and official agencies in the field of the handicapped.

5. Nephrosis. The committee on public health of the state medical society had approved, in March, of nephrosis being a crippling condition. See above. The legislature appropriated \$12,000 for the biennium beginning July 1, 1953. A plan was developed for a nephrosis program embodying these main services: Consultation to physicians; hospital care (this is limited to \$265 per patient per year because of the limited funds), post-graduate education of physicians and other professional personnel.

Several problems were reported at this meeting primarily concerned with the cost to parents of cortisone and ACTH which was not being provided under the program.

Discussion brought out the principle that, whenever possible, funds for expensive drugs such as cortisone should be provided by outside effort in order to conserve the resources of the division of crippled children for programs already in operation.

It was recommended that the present plan of services be continued for about a year before any major changes are made in the plan.

It is interesting to note that seven talks were given as of February 15 by Dr. Daniel Darrow and Dr. Robert Cooke; requested by the staffs of several hospitals as follows: Danbury Hospital; Lawrence & Memorial Hospital, New London; St. Francis Hospital, Hartford; Stamford Hospital; Hartford Hospital; and St. Raphael's Hospital, New Haven.

The total average attendance was about 30.

6. The committee reviewed the epilepsy training program for physicians that is being planned in conjunction with the St. Francis Hospital. The committee expressed that the plan of training of physicians was a worth while approach in the handling of epilepsy.

Respectfully submitted,  
Edward T. Wakeman

## REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, *Chairman*

Harold A. Bergendahl	Harry C. Knight
James C. Canniff	John O'L. Nolan
Morris A. Hankin	James H. Root

Alfred J. Sette

Activities under the direction of the committee have been more closely coordinated during the past year to serve the requirements of growing local programs.

Information concerning the activities of medical associations in all parts of the country has been assembled in service kits and these are being increasingly used by county and local committees in expanding their programs. The committee also has sponsored field meetings in several counties to aid in program development and similar meetings are being planned in other counties.

In these and other ways, information concerning the experiences of medical associations is being made available for planning at county and local levels. This fund of informative material has also proved of value in working with allied groups interested in community projects.

Activities are divided into five major fields, as follows: (1) Community Services—emergency call plans, medical forums, training of medical secretaries, local information programs and other activities; (2) Communications—press, radio and television; (3) Publications—publication and distribution of pamphlets and other printed material; (4) Exhibits—preparation of exhibits for fairs, meetings and other events; (5) Physician Information—collection and distribution of information having special interest for physicians.

The committee also has devoted considerable time to coordinating activities with national programs developed by the American Medical Association and the American Medical Education Foundation. Actions initiated in behalf of the Foundation's campaign to aid the medical schools have been too numerous to elaborate here and therefore are set forth in a separate report. One of the major AMA projects in which the committee has been active comprises the "March of Medicine" series of nation-wide television reports on medical progress. The purpose has been to build as large a Connecticut audience as possible for these programs, which have won a leading place in television.

Space does not permit complete outlining of all activities and therefore principal projects are briefly listed as follows:

*Community Service Exhibit*—A special exhibit portraying the growth of emergency medical call plans in Connecticut. Nine feet wide by seven feet high, the exhibit is designed for hospital lobbies, public libraries and municipal or other public buildings.

*Exhibits at Country Fairs*—Three of these exhibits were constructed for display at eight fairs in several sections of the state last fall. Sponsored by the Society's Committee on Rural Health, the exhibits featured the growth of Connecticut Medical Service and medical association community service programs. Members of state and county public

relations committees of the Woman's Auxiliary directed the exhibits.

*Television Projects*—The potentials of television have been further studied and the committee is participating in the activities of the recently organized Connecticut TV Committee for Health Education. Leading state-wide organizations are represented on this committee and plans are now being considered for a series of 15-minute health education programs.

Our committee is also considering sponsorship of a series of five-minute programs if suitable public service time can be arranged and if costs do not prove excessive.

*Training of Medical Secretaries*—In cooperation with the Public Relations Committee of the New Haven County Medical Association, plans were developed for a comprehensive two-year course at Quinnipiac College, Hamden, for students desiring to become medical secretaries. An advisory committee of the medical association cooperates with the college faculty in directing the course.

*Field Meetings*—Several field meetings have been conducted to assist local associations in developing community services and other activities. One of these, a press-radio conference held in Litchfield County has attracted the interest of other associations and several more conferences of this type are being planned.

*Press, Radio and Other Releases*—News of the activities of the Society and component associations was disseminated through news and radio channels during the year and a number of special articles were written for professional journals and newsletters.

*Publications and Reprints*—A new pamphlet has been published concerning the growth and operation of emergency medical call plans. Primarily intended for distribution in connection with the exhibit on these plans, the pamphlet also is available for general distribution. Revision of several similar service leaflets also have been published.

Publications and reprints of the American Medical Association and other organizations have been distributed in increased numbers to physicians, teachers, medical secretaries and community leaders.

To make these publications readily available for physicians and others who visit the Society's headquarters, a distribution rack has been installed in a central location.

*First Aid Chart*—A First-Aid Chart for home use is now in process of publication and will be distributed under direction of the Woman's Auxiliary as a feature of exhibits at country fairs next fall.

Its publication was proposed by the Public Relations Committee of the Auxiliary and instructive material has been prepared by the Society's Committee on Public Health.

In addition to distributing the chart, the Auxiliary has offered to share costs of the project.

*"Today's Health"*—The committee has directed special efforts toward encouraging wider use of "Today's Health," popular health magazine published by the American Medical Association. Subscriptions are sponsored by the Woman's Auxiliary and the committee has cooperated by publishing



information concerning the magazine in the *Connecticut State Medical Journal* and preparing exhibits for medical meetings and other events.

*Newspaper Health Column*—Titled "Your Health," this weekly column was written for Connecticut's 55 weekly newspapers throughout the year. It is published regularly in a number of these papers and in others as space permits.

*Connecticut State Medical Journal*—An increased number of special articles were written for the *Connecticut State Medical Journal*. A section on public relations activities and a special page for AMEF and other projects were also written for each issue of the *Journal*.

As mentioned in the first part of this report, increasing activities at community levels requires increasing services at state and national levels. Similar progress is reported in other parts of the country and is highly encouraging. It not only means that worthwhile projects are taking firm root at local levels, but that medical associations in hundreds of communities are gaining experiences that are being regularly recorded and studied for use by all associations in planning their programs.

In Connecticut, the development of emergency medical call plans has led all other community services and these plans are now operating in 17 principal areas. Other projects which show favorable progress comprise improvement of relations with press, radio and community groups, sponsorship of medical forums for community residents, participation in community activities and the strengthening of information programs concerning medical association services and activities.

In developing these and other programs, the committee stands ready to counsel or assist in every possible way. The sincere appreciation of the committee is extended to association officers, committee members and all other physicians who are contributing to the Connecticut program.

Respectfully submitted,  
William G. H. Dobbs

## REPORT OF THE CONNECTICUT HEALTH LEAGUE

Luther K. Musselman, *Chairman*

John W. Buckley

Wilson F. Smith

At the annual meeting of the Connecticut Health League, which was held in New Haven, on January 13, there was a panel discussion on the problems of rehabilitation, on a national, state and local level. The panel was composed of Miss Martha Potgieter, School of Home Economics, of the University of Connecticut; Mr. Edward P. Chester, Director of the Division of Rehabilitation, in the State Department of Education; Dr. John C. Leonard, of The Hartford Hospital; and Dr. A. J. Tuttle, Director of Hillside Home, Bridgeport. The moderator was Miss Mary Switzer, Director of the Division of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare, Washington, D. C. Some valuable suggestions were presented.

The Connecticut Health League is sponsoring a conference on the "Problems of Aging," to be held at Rocky Hill, April 7 and 8, 1954. The meetings are open to all professional and lay persons interested in this subject.

### *The purposes:*

- (1) to state the problems.
- (2) to review available information and data.
- (3) to evaluate the applications of facilities and adequacy of programs conducted in Connecticut
- (4) to evolve a plan of action for the participating agencies and
- (5) to present a summary for lay people to stimulate community action.

### *Areas of interest:*

The following six subjects will be explored and considered, each under the leadership of the Chairman indicated.

Care of the Aged, Dr. John C. Leonard.

Rehabilitation of the Aged, Dr. Thomas F. Hines.

Health Maintenance for the Aged, Dr. Harold S. Barrett.

Chronic Illnesses of Older People, Dr. Alfred L. Burgdorf.

Education and Recreation for the Aged, Dr. Alan Hugg.

Employment and Retirement of the Aged, Mr. Milton L. Shurr.

At the Thursday afternoon meeting, a general summary of the six subjects will be presented.

Respectfully submitted,  
Luther K. Musselman

## REPORT OF THE JOINT COMMITTEE ON PSYCHIATRIC SERVICE IN GENERAL HOSPITALS

### *Society Representatives*

Thomas C. Carey

Gray Carter

Clifford D. Moore

### *Connecticut Hospital Association Representatives*

Albert W. Snoke, *Chairman*

Mr. Philip Johnson

Mr. Charles V. Wynne

### *Public Service Representatives*

Elias J. Marsh

Edgar C. Yerbury

Your committee has had a meeting for organization on November 12, 1953 and one meeting of the full committee since that time. There is general agreement that psychiatric care of patients in general hospitals—both in-patient and out-patient—can be materially improved in the State of Connecticut. There was also a general consensus of opinion that provision of adequate in-patient and out-patient facilities in a number of the larger general hospitals throughout the state of Connecticut would not only render better service to the patient requiring this type of care in the local community, but would also enable patients with mental disease to be screened more carefully and, in many instances, avoid commitments to state institutions.

It is planned that the deliberations and conclusions of this committee will be developed in close cooperation with the Administration of the State of Connecticut and particularly the new Commissioner on Mental Hygiene. It is hoped to have a formal report for presentation by the Fall of 1954.

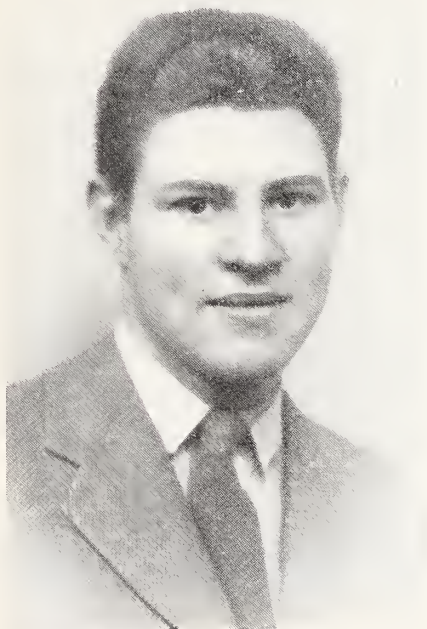
Respectfully submitted,  
Albert W. Snoke

(To be continued)

## OBITUARY

### Edward Rogerson Bagley, M.D.

1922 - 1954



A doctor's life, however short, can prove a rich blessing to mankind and show grandly before the face of heaven that the Most High hath given knowledge to men that He may be honored in His wonders. Edward Rogerson Bagley was born April 12, 1922 in Bridgeport, Connecticut. He spent most of his boyhood, however, in Hartford, attended St. Thomas's Seminary, graduated from Holy Cross College in 1943, Georgetown Medical School in 1946. We began to know him when he interned at St. Francis' Hospital in 1946 to 1947. But quickly, he went from our midst to serve his country as a medical officer with the United States Air Force. He served his country well and for three long years. Coming out of the service, he served a residency in pediatrics at the Gallinger Municipal Hospital in Washington, D. C. He came back to us in 1952 and shortly developed a very nice practice in the field of pediatrics.

All of us who knew him were aware of an intense devotion to his practice. It was evident that children

were his first love and that this choice of his specialty was the real vocation of his life. At home he was a solicitous father and husband. In the sick room with children he appeared to be as concerned about each one as if it were his own. A varying degree of health did not become an impediment to the carefulness of his duty. Night and day the cry of an ailing child met instant response. Personal inconvenience was never a part of his being.

The interns with whom he was associated bear superlative witness to his kindly manner and willing cooperation. Next to his devotion to his children was this urge always to be of help to those who came to learn from him and his knowledge, and of this he gave unstintingly.

His was a particularly inquisitive mind. Interested beyond the problems of medicine, he showed a certain philosophical nature that impelled him to study problems that came his way to their end. This might have appeared to some to be reason for an unusual seriousness at times, and yet were they to probe more deeply, they would come to discover the enjoyment he took in this search for the causes of things.

Death has robbed us prematurely of a doctor deeply devoted to his profession and of a gentleman whose mind took and gave pleasure in intellectual pursuits. We are saddened by his loss, and we take this occasion to offer sincere sympathy to his wife and children in their bereavement.

Maurice W. Kearney, M.D.

### Tumor Clinics Association Elects

At the Annual Meeting of the Association of Connecticut Tumor Clinics held at New Britain, April 15, the following officers were elected for the year 1954-1955: Chairman, Paul Rosahn, New Britain; Secretary, Robert Tennant, Hartford; Assistant Secretary, Christie McLeod, Middletown; Executive Committee, Louis Simon, Norwalk, and John Thayer, Hartford.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Newell W. Giles, Darien*

*President-Elect, Mrs. Norman J. Barker, Collinsville*

*First Vice-President, Mrs. J. ALFRED WILSON, Meriden*

*Second Vice-President, Mrs. Frank L. Polito, Torrington*

*Recording Secretary, Mrs. Charles Culotta, Hamden*

*Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob*

*Treasurer, Mrs. Joseph Woodward, New London*

### State Meeting

Middlesex County played host to the State Auxiliary when it met at Trinity College on April 28 for its annual meeting. At the business meeting Mrs. F. Erwin Tracy presented a report in her capacity as chairman of the Revisions Committee. Election of officers took place with the following results: President, Mrs. Newell Giles; President-Elect, Mrs. Norman Barker; 1st Vice-President, Mrs. J. Alfred Wilson; 2nd Vice-President, Mrs. Frank L. Polito; Treasurer, Mrs. Joseph Woodward; Corresponding Secretary, Mrs. C. Murray Gratz; Recording Secretary, Mrs. Charles Culotta.

With the assistance of Mrs. Richard Karpe, State Mental Health chairman, Mrs. Winfield O. Kelley, program chairman, secured Dr. John Blasko, newly appointed State Commissioner of Mental Health, as the guest speaker.

#### PHYSICIANS ART EXHIBIT

Auxiliary members came away with the majority of the awards presented to exhibitors at the Physicians Art Exhibit. First award and honorable mention were given to Mrs. Wilson Powell and Mrs. Merrill B. Rabinow, respectively. First award in portrait went to Mrs. David Waskowitz; honorable mention went to Mrs. Nicholas Marinaro. Mrs. Marinaro also received the first award in water color and Mrs. Powell was given honorable mention. In pastels, Betsey Waskowitz received honorable mention. Mrs. Ernest Rosenthal won first award in photography. Ceramics first award went to Mrs. Gerald Greene; honorable mention to Mrs. Alyce Kleinmann. Mrs. Alexander Marsh was awarded first prize in sculpture.

#### ANNUAL REPORTS

Following is the list of counties with their total paid membership for 1953 and changes which took place within the year. These figures were sent to me by the county membership chairmen and checked against my file. There are several discrepancies but on the whole they agree.

	TOTAL PAID	NEW	REINSTATED	TOTAL 1953 NEW	TRANSFERRED	RESIGNED	DROPPED	9 3 DUES UNPAID	CEASED
Fairfield	226	37		37		3	6		
Hartford	406	41	2	43	2	1	1		2
						(courtesy)			
Litchfield	57	1		2					
Middlesex	57	2		2		2			
New Haven	277	7		7	2	6			1
New London	106		1	10		1			
Windham	40	1		1					
Tolland									
(Member-at-large)	1								
	1,170	89	3	102	4	13	7		3

Emma V. Giles,  
First Vice-President

#### AMERICAN MEDICAL EDUCATION FOUNDATION

The American Medical Education Foundation is maintained by annual gifts. This means that the auxiliaries, as well as the physicians, are called upon to make annual contributions. All the county auxiliaries in Connecticut have contributed for 1954, reporting as follows, the money either voted from the budget or raised by projects.

COUNTY	AMOUNT	PROJECT
Fairfield .....	\$350	Bridge parties, dance
Litchfield .....	50	Dance
Middlesex .....	57	
Hartford .....	400	Card party
New Haven .....	100	
New London .....	25	
Windham .....	25	
State Auxiliary .....	200	
	\$1,207	

This is a creditable increase over last year's \$725 total from Connecticut Auxiliaries.

Katharine W. Wakeman,  
AMEF Chairman

## FEDERAL LEGISLATION

The year 1953-54 has been rather an inactive one from a legislative viewpoint. The Connecticut Legislature was not in session, and the only bill which the National Auxiliary asked us to actively support was the Bricker Amendment. The Connecticut Woman's Auxiliary decided not to take action because it was felt our members were not sufficiently informed as to why the AMA was supporting, in principle, the Bricker Amendment. An effort was made to supply the membership with material and information.

Other legislative measures studied in the counties were HR8356 (Wolvertown) Health Reinsurance Fund; S2759 To Amend the Vocational Rehabilitation Act; S2778 and HR7397 Public Health Service Grants-in-Aid; HR3706 Legislation to end Discrimination of Doctors and Dentists Draft; HR7199 Social Security Extension, and legislation concerning veterans' medical care.

Ruth Russell,  
Legislation Chairman

### Dr. Upson Named President-Elect, Connecticut Public Health Association

Dr. William H. Upson, Suffield health director and past president of the Hartford County Medical Association, was named president-elect of the Connecticut Public Health Association at the annual meeting of the organization May 13, in Meriden.

Miss Dorothy Wilson, executive director of the New Haven Visiting Nurse Association, president-elect of the association, assumed office as president for the 1954-55 term.

Dr. Edward M. Cohart, associate professor of public health, Yale University, was elected vice-president and Miss Irma Biehuse, service director, Connecticut Branch of the American Cancer Society, was reelected secretary.

Members of the association elected Miss Eloise L. Keckeforth, chief consultant in nutrition, Connecticut State Department of Health, as treasurer, and named two new members of the board of directors for three year terms, Leslie K. Sherman, principal sanitary engineer, State Department of Health, and Miss Jessie P. Halbert, executive director of the Meriden Public Health and Visiting Nurse Association.

Dr. Harold A. Barrett, deputy state commissioner of health, was elected as delegate to the American

Public Health Association, and Dr. Upson was named alternate delegate.

### Arnold P. Olson Appointed Executive Secretary, Fairfield County Medical Association



Appointment of Arnold P. Olson, Fairfield, as full-time executive secretary of the Fairfield County Medical Association was announced May 7 by Edwin R. Connors, secretary of the Association, following a meeting of the Board of Trustees.

Mr. Olson is a native of New York and has been engaged in sales promotion and trade and professional association activities in the Bridgeport area since 1946. Prior to that time, he served on the editorial staff of the *Bridgeport Times-Star* and as editor of the *Fairfield News*. Until recently, he has been associated with the home building industry, having served as executive secretary of the Greater Bridgeport Builder's Association. He is a graduate of Bridgeport Central High School and the Junior College of Connecticut.

Mr. Olson is president of the Fairfield Rotary Club and is active in community affairs. He resides with his family at 265 Sturges Road, Fairfield. Mrs. Olson is the former Blanche Martin and their two children include a son, A. Park Olson, Jr., a student at Roger Ludlowe High School, and a daughter, Neilla, a student at Mill Plain School.



## SPECIAL NOTICES

### XIVTH INTERNATIONAL CONGRESS ON THE HISTORY OF MEDICINE

September 13 - 20, 1954

Rome, Italy

### HEMISPHERE CONGRESS ON EYE DISEASES AND PREVENTION OF BLINDNESS

Specialists in diseases of the eye and workers in the field of prevention of blindness in the Western Hemisphere will gather in Sao Paulo, Brazil, June 14 to 21, for the Third Interim Congress of the Pan American Association of Ophthalmology, under the presidency of Dr. Moacyr E. Alvaro of Sao Paulo, and a Congress on the prevention of Blindness and the Welfare of the Blind. This gathering is one of many distinguished events in the celebration of the four hundredth anniversary of the founding of Sao Paulo now in progress.

The program of the Congress of Ophthalmology, which meets June 17-21, will include papers by several physicians of the United States.

Presentations will be in English, Spanish or Portuguese, with simultaneous translation into the other two languages.

From June 14 to 16 will take place the Congress on the Prevention of Blindness and the Welfare of the Blind, during which several representatives of U. S. organizations in this field will be guest speakers.

The Association now has 1,500 members in twenty-two countries. Its meetings are held in North, Central and South America in rotation.

### COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association announces that its Sixth Annual Course in Postgraduate Gastroenterology will be given at The Shoreham in Washington, D. C. on October 28, 29, 30, 1954.

The Course will again be under the direction of co-chairmanship of Dr. Owen H. Wagensteen, professor of surgery of the University of Minnesota Medical School, who will serve as surgical coordinator and Dr. I. Snapper, director of Medical Education, Beth-el Hospital, Brooklyn, N. Y., who will serve as medical coordinator.

Drs. Wagensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools and Walter Reed Army Hospital, whose presentations will cover all phases of gastrointestinal diseases and problems.

The entire session on Friday, October 30, 1954 will be given at the Walter Reed Army Hospital.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 33 West 60th Street, New York 23, N. Y.

### 79TH ANNUAL MEETING OF THE AMERICAN NEUROLOGICAL ASSOCIATION

The 79th Annual Meeting of the American Neurological Association will be held from June 14 to 16, 1954, at the Hotel Claridge, Atlantic City, N. J.

### FIFTH INTERNATIONAL CONGRESS ON MENTAL HEALTH

The Fifth International Congress on Mental Health will be held August 14 to 21 at the University of Toronto, with the theme "Mental Health in Public Affairs." The Congress will include Technical Sessions in the mornings, and Round Tables in the late afternoons. This Congress will be preceded on August 13 and 14 by an International Institute on Child Psychiatry, with the theme "The Emotional Problems of Children under Six." This Institute will feature small working groups, larger Group Meetings, and the presentation of papers by Dr. Georges Heuyer, Dr. Emanuel Miller and Dr. Benjamin Spock.

### INTERNATIONAL CONGRESS FOR PSYCHOTHERAPY

The International Congress for Psychotherapy will be held July 20 to 24, 1954, at the Congress House, Zurich, under the patronage of the Swiss Association of Medical Psychotherapists. The subject of the Congress will be "Transference in Psychotherapy." Speakers will include Prof. W. Gut, Prof. D. Lagache, Dr. J. Bierer, Dr. J. L. Henderson, Dr. F. Alexander, Dr. J. N. Rosen, Dr. Gerhild V. Staabs, Prof. R. Sarro-Burkano, Prof. K. Goldstein, Dr. J. Schotte, and Prof. Graf K. v. Durckheim.

## THE DOCTOR'S OFFICE

Ronald W. Cooke, M.D. announces the opening of an office for the practice of general and pediatric surgery at 1001 Farmington Avenue, West Hartford.

George Flanagan, M.D. announces the opening of an office for the practice of general medicine at 132 Boston Post Road, Waterford.

Clinton S. Scholes, Jr., M.D. announces the opening of an office for the practice of general and traumatic surgery at 464 Montauk Avenue, New London.

## NEWS

### *from County Associations*

#### Fairfield

Russell A. Keddy, chief of the Radiology Department of Stamford Hospital was elected president of the Fairfield County Medical Association at the annual meeting of the Association held in the Stratfield Hotel in Bridgeport on April 13. Other officers appointed were Nathaniel B. Selleck of Danbury as vice-president, Joseph C. Quatrano of Bridgeport, treasurer, Edwin R. Connors of Bridgeport, secretary, C. Louis Fincke of Stamford, councilor and John P. Gens of Norwalk, alternate councilor. The Association approved the appointment of a full time executive secretary, Mr. Arnold P. Olson of Fairfield, who will open an office for the Association in Bridgeport. Louis Rogol of Danbury and Cotton Rawls of Stamford were appointed members of the Board of Trustees and C. Stanley Knapp was appointed to the Professional Relations Committee of the Connecticut State Medical Society. Guests present at the meeting included George H. Gildersleeve of Norwich, president of the Connecticut State Medical Society; Thomas Danaher of Torrington, chairman of the Council of the State Society; Creighton Barker, executive secretary of the State Society; James G. Burch, Public Relations director; Stanley H. Osborn, commissioner of the State Department of Health, and Edmund L. Douglass, delegate from New London County Medical Association.

Thirty new members were added to the roster of the association, the largest number in many years. Clifton C. Taylor of Bridgeport who retired as treasurer has held this office in the County Association for twenty-one years and the president thanked Dr. Taylor for his many years of valued service to the Association.

C. Louis Fincke was chosen chairman of the Board of Trustees of the Fairfield County Medical Association at an organizational meeting held in Bridgeport at the University Club on May 6. The board instructed the secretary to invite the Connecticut State Medical Society to hold the 1955 annual meeting in Fairfield County and appointed a committee on local arrangements.

Joseph J. Lankin, consultant in rheumatic diseases

at Hartford Hospital and Rocky Hill Hospital for Chronic Disease, delivered a paper entitled, "The Present Status of Therapy in Rheumatoid Arthritis" at a joint meeting of the Bridgeport Medical Association and the Arthritis and Rheumatism Foundation on May 4 in the auditorium of St. Vincent's Hospital in Bridgeport. Dr. Lankin conducted a teaching clinic at Bridgeport Hospital on "The Differential Diagnosis of Joint Conditions" during the afternoon.

Oliver L. Stringfield, president-elect of the Connecticut State Medical Society and chairman of the AMA Section on Pediatrics, delivered one of the lectures at the Health Fair held in Randolph, Vermont on May 10. Dr. Stringfield's subject was "Diseases of Children."

William Kaufman of Bridgeport is the author of "Some Psychosomatic Aspects of Food Allergy" published in *Psychosomatic Medicine*, January, February, 1954.

Kirby S. Howlett, Jr., of Shelton addressed the Rhode Island Medical Society at its annual meeting in Providence in May on "Medical Treatment of Pulmonary Tuberculosis."

#### Hartford

County health officers were called together by HCMA's committee on communicable diseases to review their problems in the polio vaccine trials. Indications were that almost all had solved their administrative and mechanical problems.

Manchester doctors Merrill B. Rubinow and Edmond R. Zaglio lectured this month at Civil Defense Refresher Courses for inactive nurses.

Dr. Harold S. Barrett, deputy commissioner of the State Department of Health, spoke in Manchester about a possible ban on the importation of parakeets from out of State.

In March Samuel Donner was elected president of the McCook Memorial Hospital staff at its annual meeting. Claude C. Kelly was named vice-president and D. Dillon Reidy, secretary. Morris Tuch was appointed staff consultant in obstetrics. One year appointments to the visiting staff include Raymond S. Holtz, attending obstetrician; Richard C. Buckley and William D. Scoville, neurosurgeons; Sidney R. McPherson and Sydney Sewall, orthopedic surgeons; Francis W. Brecker, dermatologist and Timothy L. Curran, otolaryngologist.

One year appointments to the associate visiting staff include: in medicine, Charles E. Roh, Gideon



R. Wells, Donald R. Hazen and William F. Prestley; in surgery, Morton Opinsky and Maurice F. Mulville; ophthalmology, Thomas J. Mirabile; medicine, William H. Glass, Franklin B. Watters, Joseph Kaschmann, Rowe A. Castagno, Edward Scull, Archie J. Golden, Daniel Marshall and Theodore Steege; in obstetrics, Robert C. Emmel, Marvin H. Grody, M. A. Crispin, Dwight Wood; thoracic surgery, R. Leonard Kemler and Donald R. Morrison.

Also in March the Hartford County Chapter of the American Academy of General Practice elected Michael J. DeVito president. Norman D. Markley was elected vice-president, George J. Sneiderman, secretary, and Joseph Raffa, treasurer. John M. Monacella, retiring president, was elected to the board of directors for one year, Clarence M. Friery for three years.

The new chairman of the Board of Directors of HCMA for 1954-55 is Stewart P. Seigle, a Hartford internist. Dr. Seigle is a graduate of Wesleyan University and Harvard Medical School. He is on the assistant staff at Hartford Hospital and the attending staff at the Newington VA hospital.

New officers of the Woman's Auxiliary to the Hartford County Medical Association are: Mrs. Robert Tennant, president; Mrs. Charles Sullivan, president-elect; Mrs. Nicholas A. Marinaro, first vice-president; Mrs. Gerald S. Greene, second vice-president; Mrs. George Rosenbaum, recording secretary; Mrs. William H. Horton, corresponding secretary; Mrs. Robert Osmond, treasurer, and Mrs. Joseph N. Russo, assistant treasurer.

For the past year the Auxiliary reports the following highlights: a tea and tour of the Newington Home for Crippled Children, participation in the Art-Musicale at the Wadsworth Atheneum, a compilation of a membership directory and revision of the by-laws.

The Auxiliary played a major role in the 1953 Diabetes Drive, collecting samples and delivering them to testing stations. Members also staffed HCMA's special exhibit at the Hartford Times Travel Show.

During the year the medical and surgical relief committee collected and packed 99 cartons of drugs for delivery overseas, and a contribution of \$400 was sent to the American Medical Education Foundation and three nursing students and three medical students were awarded scholarships this year.

Robert P. Knapp of Manchester, medical director of Cheney Brothers for over 30 years, died at Manchester Memorial Hospital in March after a long illness.

Christopher W. Mac Minigal of Hazardville died on May 3 after a long illness. He was formerly a practising physician in Hartford and for twenty years was a member of the Hartford Board of Health.

Thomas F. V. La Porte, medical director of Bristol plant of New Departure Division, General Motors Corporation, addressed a conference of G. M. physicians in Chicago in April. Dr. La Porte described the remarkable results obtained from the use of foam rubber in industrial medicine based on a three year study in which 500 cases were evaluated. The use of foam rubber has been found to materially reduce the period of disability and deformity as well as to increase employee comfort and wellbeing.

Douglas J. Roberts of the radiology staff at Hartford Hospital was recently elected president of the New England Cancer Society at the annual meeting held in Bar Harbor, Maine.

Ralph Andrews is the new encephalographer of Hartford Hospital. Dr. Andrews comes here from the Norwich State Hospital. He is a graduate of the Boston University School of Medicine, is married and lives with his family in Coventry.

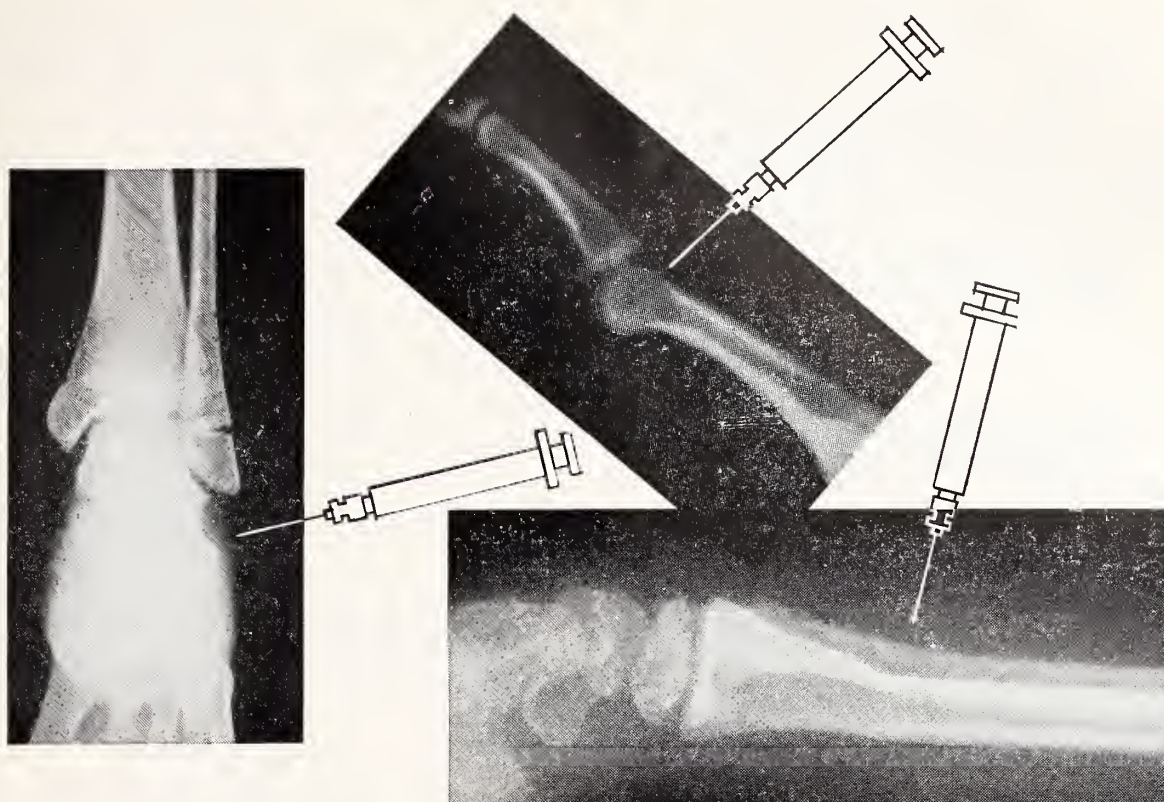
## Litchfield

The 190th annual meeting of the Litchfield County Medical Association, held at Deer Island Gate on Bantam Lake, was preceded by an excellent steak dinner.

The Pharmacists' Association of Litchfield County invited the members of Litchfield County Medical Association to be their guests at a dinner party to be held at the Torrington Country Club, on Tuesday, May 18, 1954. This was unanimously accepted.

Fairfield County was represented by its perennial delegate, James Douglas Gold. Archibald W. Thompson represented Middlesex County. Morris Coshak represented New Haven County. Each of these men brought greetings from his respective county.

Following the business meeting, James C. Hart, director of the Bureau of Preventable Diseases, Connecticut State Department of Health, spoke on "Polio Vaccine Field Trials." Dr. Hart outlined the national



## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery<sup>1</sup> where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means<sup>1,2</sup> of accelerating dispersion of accumulated fluids.*

Swenson<sup>2</sup> has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.



polio Foundation plan for the administration of the Salk polio vaccine and emphasized the part to be played by Hartford, Fairfield and Litchfield Counties, the three counties selected in Connecticut to participate in the field trial. Dr. Hart's talk was very stimulating and produced a number of questions and comments from interested members.

The following officers were elected for the coming year: Francis A. Sutherland of Torrington, president; Richard I. Barstow of Norfolk, vice-president; John F. Kilgus, Jr., secretary-treasurer; Frank D. Ursone of Norfolk, councilor; W. Bradford Walker of Cornwall, alternate councilor.

Frederic W. Wesebe of Washington, Connecticut, past president of the Litchfield County Medical Association, died in the Grace-New Haven Hospital on May 8 after a long illness. Dr. Wesebe was chairman of the Washington Board of Education at the time of his death.

### Middlesex

Herbert Levine read a paper at the meeting of the American Physiological Society in Atlantic City on April 12.

Nina Toll, who was on the staff of the Connecticut State Hospital for seven years, has gone into private practice. Her office is at 159 Broad Street in Middletown. She is limiting herself to the practice of psychiatry.

Joseph Magnano was elected president of the Connecticut State Society of Anesthesiologists.

Two promotions were recently announced at the Connecticut State Hospital. They were to Aldo Santiccioli who became clinical director, and to John C. Statham who became physician-psychiatrist.

Edgar C. Yerbury and Jorge Paras attended the annual meeting of the American Psychiatric Association in St. Louis early in May.

### New Haven

Gustaf E. Lindskog of New Haven was one of the guest speakers at the annual meeting of the Rhode Island Medical Society held in Providence in May. His subject was "Present Trends in the Surgery of Pulmonary Tuberculosis."

At the New Haven Medical Society on April 21 James L. Poppin, Department of Neurosurgery,

Lahey Clinic, Boston, spoke to the Society on "General Neurosurgical Problems." On May 5 Bently Colcok from the Lahey Clinic spoke to the Medical Association on the "Surgical Treatment of the Thyroid Gland."

### New London

The monthly dinner lecture meeting of the Lawrence and Memorial Associated Hospitals was held April 15. The speaker was Allen D. Callow, assistant professor of surgery, Tufts College Medical School, and surgeon at the New England Medical Center. His subject was "Vascular Grafts for Arteriosclerosis."

Ruth Whittemore, associate clinical professor of pediatrics at Yale University Medical School, spoke on "Congenital Heart Disease" at the monthly cardiac-vascular lecture of the New London Chapter of the Connecticut Heart Association on April 22.

### Tolland

The Annual Meeting of the Tolland County Medical Association was held on April 20 at the Olde Homestead Inn, Somers. The speaker was Louis P. Hastings of Hartford who discussed "Recent Advances in Hematology." Guests included Stanley H. Osborne, State Health Commissioner, and William H. Horton of CMS.

Officers were elected as follows: President, Francis Burke, Rockville; Treasurer-Secretary, R. B. Thayer, Jr., Hazardville; Vice-President, Dr. William Schneider, Rockville; State Committee on Professional Relations, Seymour Kummer, Rockville.

---

### American Medical Writers Association Scholarships

The American Medical Writers Association has just announced the acquisition of another scholarship for its collegiate courses in medical journalism. These courses are creating considerable interest among students in the mid West. The latest scholarship was given by the president of the Yorke Publishing Company, M. T. Wisotzkey, who inaugurated the *American Journal of Medicine* and is a contribution from this publication and from the *American Journal of Surgery*.



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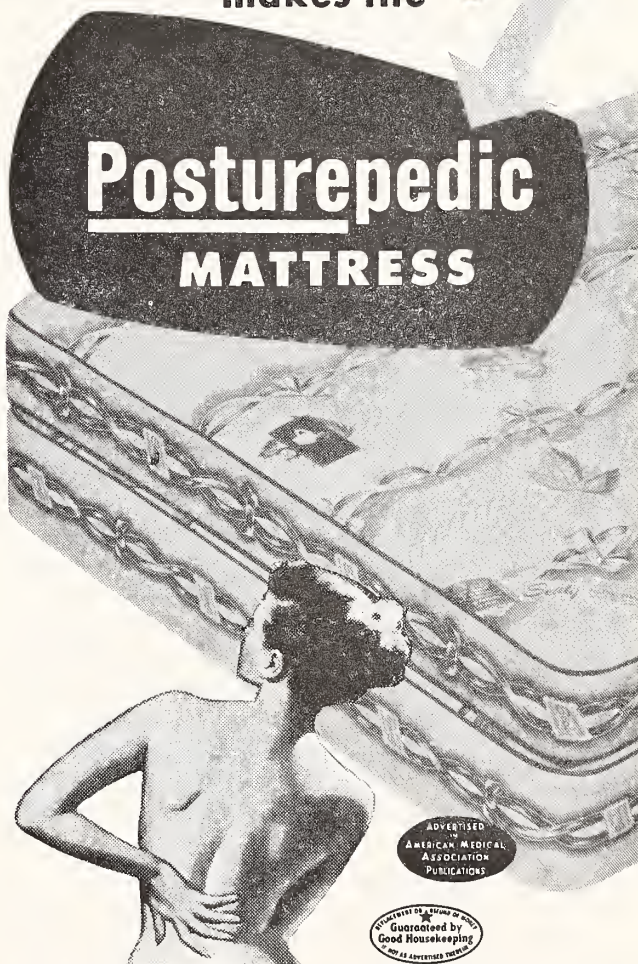
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## NEW BOOKS IN REVIEW

*MICHAEL SERVETUS.* By Charles Donald O'Malley. Philadelphia: American Philosophical Society. 1953. 208 pp. \$3.

Reviewed by STANLEY B. WELD

This volume represents the first translation of the scientific and medical writings of this 16th century theologian-scientist. In addition to a foreword and an introduction there are six chapters, two of them dealing with Servetus' two editions of Ptolemy's Geography, one with Servetus "Apologia" one with "An Apologetic Discourse in Favor of Astrology," another with his "Christianism Restitutum," and the major part of the volume with his little book, "On Syrups."

The introduction contains a short biographical account of Servetus. This author expresses the opinion that while studying medicine in Paris, Servetus was a dissector for Guenther following the noted Vesalius. Bainton, on the other hand, in his "Hunted Heretic"\* quotes Guenther as stating that Servetus was a colleague of Vesalius at the dissecting table.

Servetus goes into great detail in "The Syrups" in supporting the views of Galen in opposition to the Arabian school of thought. It is tedious reading for the most part but viewed in retrospect reveals how contentious were the times then in attempting anatomical and physiological, to say nothing of chemical, solutions of processes in the human body with only a limited knowledge at hand.

Servetus' solution of the circulation of the blood through the lungs will always remain a classic. We prefer to remember Servetus for this discovery rather than for his violent opposition to infant baptism and his theological controversy with John Calvin which brought about his death at the stake in Champel.

Professor O'Malley, historian and student of Renaissance medicine, pays a gracious tribute in the foreword to the members of the Department of the History of Medicine in Yale University and in particular to the Sterling Professor of the History of Medicine, John F. Fulton. The Historical Library at Yale supplied all the illustrations for this volume.

\*See Book Review, JOURNAL, February 1954

*THE PSYCHOSOMATIC CONCEPT IN PSYCHO-ANALYSIS.* Felix Deutsch, Ed. New York: International Universities Press, Inc. 1953. 182 pp. \$4.

Reviewed by RICHARD KARPE

Two years ago the Boston Psychoanalytic Society conducted a symposium on psychosomatic medicine. Theoreticians of psychosomatic medicine were gathered together to present a series of papers on their views and philosophy with regard to psychosomatic problems. These papers and the discussion which followed are now published as No. 1 of the Monograph Series of the Boston Psychoanalytic Society and Institute. The clinician might not find it easy to read

most of those learned and scholarly papers because the main focus is theoretical rather than practical. Felix Deutsch, the pioneer of psychosomatic medicine, introduces and summarizes the discussion and limits himself to a rather brief statement.

The first paper, written by Sidney Margolin, deals with the "Genetic and Dynamic Psychophysiological Determinants of Pathophysiological Processes." Margolin, an original thinker and leader in this field, is known to the readers of this JOURNAL for his introduction of the anaclitic treatment of colitis. He emphasizes the need for the investigation of psychophysiological mechanisms as they occur in healthy and sick people. Psychosomatic symptoms are understood as regressive states. Repressed "fantasies of function" return as psychophysiological components of mood and affect states. The more archaic the "fantasy of function," the more autonomously the organ functions and the less central integrative regulation participates. The brain, so to speak, disregards the organ which ceases to operate in the interests of a coordinated economy. Margolin's concept of "fantasy of function" is demonstrated in an adolescent boy whose conflict with his mother became conscious and obvious with the onset of diabetes. Identifying mother and food he became unable to utilize food and equated this inability to his mother's withdrawal of love. His regulation of his own insulin represented his independence from the internal functioning of his pancreas.

In the next paper, "Some Current Trends and Hypotheses of Psychosomatic Research," Roy Grinker is critical of all psychosomatic research because each investigator sees only a small part of the field in which the psychosomatic problem should be investigated. He demands that interdisciplinary groups be formed. He realizes that they are rare, that it is difficult to initiate them, and that it is even more difficult to integrate them into a workable and working team. The whole group must be subjected to lengthy and repetitive educational processes. He declares that the need of psychosomatic research in our time is the formation of such groups. The group method, however, is time consuming and costly and not generously supported by foundations.

The "Problem of Specificity in the Psychosomatic Process" is discussed by Lawrence Kubie. He denies that the question of how the psychosomatic process arises can yet be answered. As long as we cannot do that we cannot find specific factors for psychosomatic dysfunction.

A very interesting contribution is a preliminary research report of Margaret Gerard whose paper is entitled "Genesis of Psychosomatic Symptoms in Infancy." She reports research on thirty-eight cases of psychosomatic conditions where facets of mother behavior were investigated from different points of view—psychoanalytically, medically, and sociologically. These mothers were found to be narcissistic and disinterested in their children except as self-enhancing assets. They resented the exertion involved in child care and rarely gained pleasure from the mother-child relationship. Dr. Gerard then tries to differentiate the material conduct that may contribute to a predisposition for psychosis from that which may contribute to the predisposition for a psychosomatic disorder. She considers the number of her cases statistically not valid enough for more than a sugges-

tion and a tentative theory. The results have to be taken with caution and not overestimated or oversimplified, which is a frequent danger of such preliminary publications. The research is still continued through the support of the Field Foundation.

Ralph Kaufman headlines his contribution "Problems of Therapy" but does not limit himself to the discussion of treatment. He gives an historical review of many psychoanalytic papers and touches on many problems of theory. He tries to show that the various forms of goal-limited therapists utilize the different stages in the development of psychoanalytic therapy. Only at the end of his contribution does Kaufman present some clinical problems from his hospital. The most impressive one occurred in two cases of ulcerative colitis in which psychotherapy seemed to fail until the patients were told, "if you don't stop bleeding, you will die." This confrontation with death remarkably helped, but a procedure which certainly shouldn't be lightly initiated.

The papers are discussed by the members of the Boston Society. Ives Hendrick proposes an hypothesis of physiologic infantilism in an organ system and is supported by Bernard Bandler. Joseph Michaels wants to establish a psychosomatic quotient and substitutes physiologic regression for physiologic infantilism. Elizabeth Zetzel wonders about constitutional predisposition for psychosomatic conditions. She discusses the value of anacritic treatment for those patients who had suffered great deficiencies in infantile gratification by their mothers. Greta Bibring discusses favorably Margolin's contribution to the symposium. Felix Deutsch suggests twelve points on which the choice of organ in a neurosis depends. Lucie Jessner emphasizes the importance of early mother-child relationship for the predisposition to psychosomatic illness. Lydia Dawes emphasizes the father's influence on the mother-child relationship. And finally William Murphy emphasizes the value of sector psychotherapy as introduced by Felix Deutsch.

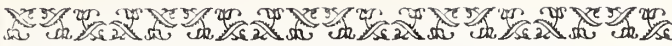
This symposium will be of great value to anyone interested in the theoretical aspects of psychosomatic medicine but will be of limited use to the practicing clinician.

THOUGHTS ABOUT LIFE. By Felix Friedberg. New York: Philosophical Library. 1954. 40 pp. \$2.50.

Reviewed by STANLEY B. WELD

Occasionally it is refreshing to turn to subjects outside one's field of specialization and possibly get a different concept of some of life's problems Here we have five essays by a college teacher on topics which should be the concern of every thinking person. The quotation from Albert Schweitzer, known by name to every American, which appears in the front of the volume commands attention: ". . . if only we would all give up three minutes every evening to gazing up into the infinite world of the starry heavens and meditating on it, or if in taking part in a funeral procession we would reflect on the enigma of life and death, instead of engaging in thoughtless conversation as we follow behind the coffin . . ." A tough job for most of us today with our television, cineramas and motor car races!

Here are the subjects of the essays: "Ideation or Reality," "The Function of a University," "Philosophy's Service to the Scientist," "A Work of Art," and "Characteristic Phenomena of Living Things." There are nuggets to be found in all of them. For example, in the first the primary goal of education



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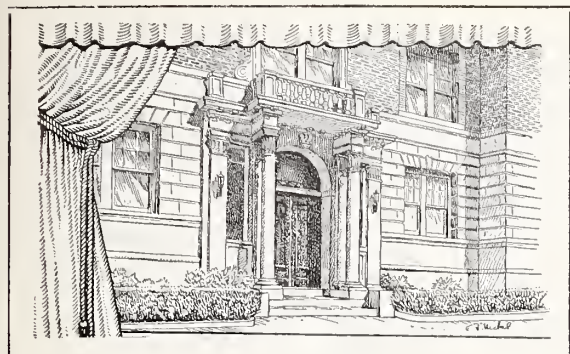
is emphasized to develop in youth, tolerance, fairness and understanding. Again, the function of a university in this day of red chasers is pointed out succinctly. Philosophy is proposed as an aid to science "in dissolving the conflict between science and religion."

In the final chapter the essayist discusses certain processes of physics and chemistry as they are related to plant and animal life, the concept of homeostasis, and the hereditary disease alcaptonuria.

## Working On After 65

Contrary to the general impression that age 65 usually marks the end of productive life, a relatively large proportion of American men past that age are still actively at work, according to the Metropolitan Life Insurance Company's statisticians.

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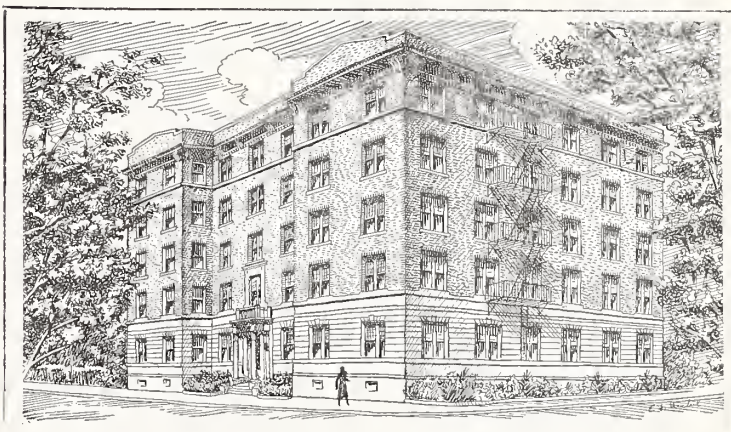
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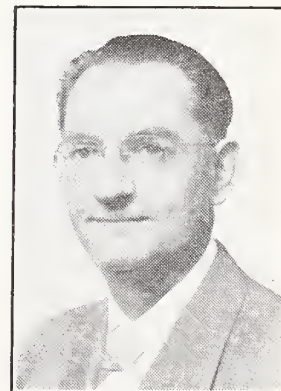
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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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## HYSPERSPLENISM

## INDICATIONS FOR SURGERY

THEODORE S. EVANS, M.D., LEVIN L. WATERS, M.D., and ROBERT M. LOWMAN, M.D., *New Haven*

Dr. Evans. *Director of Medical Service, Memorial Unit, Grace-New Haven Community Hospital; Clinical Professor of Medicine, Yale University School of Medicine*

Dr. Waters. *Director of Pathology Department, Memorial Unit, Grace-New Haven Community Hospital; Associate Professor of Pathology, Yale University School of Medicine*

Dr. Lowman. *Director of X-ray Department, Memorial Unit, Grace-New Haven Community Hospital; Assistant Clinical Professor of Radiology, Yale University School of Medicine*

## INDICATIONS FOR SURGERY

## I. Primary

- A. Congenital Hemolytic Anemia.
- B. Acquired Hemolytic Anemia.
- C. Idiopathic Thrombocytopenic Purpura.
- D. Splenic Neutropenia.
- E. Splenic Pancytopenia.

## II. Primary Recurrent: Due to Accessory Spleens or Splenic Implants

- A. Congenital Hemolytic Anemia.
- B. Idiopathic Thrombocytopenic Purpura.
- C. Splenic Neutropenia.

## III. Secondary: Occurring in Chronic Disease

- A. Acquired Hemolytic Anemia.
- B. Thrombocytopenic Purpura.
- C. Splenic Neutropenia.
- D. Splenic Pancytopenia.

## PRIMARY HYPERSPLENISM

## CONGENITAL HEMOLYTIC ANEMIA

- A. Splenectomy: life saving during crises
- B. Transfusions: not used during crises
  1. Danger hemolysis and renal "shutdown"
  2. Rise in blood volume—"auto-transfusion"
- C. No abnormal operative bleeding
- D. Splenectomy prevents or terminates
  1. Chronic invalidism
  2. Cardiac dilatation
  3. Cholelithiasis
  4. Gout
- E. Splenectomy terminates crises and restores hematologic balance

## ACQUIRED HEMOLYTIC ANEMIA

- A. Splenectomy: life saving during crises
- B. Transfusions: not used during crises
  1. Danger hemolysis and renal "shutdown"
  2. Rise in blood volume—"auto-transfusion"
- C. No abnormal operative bleeding
- D. Splenectomy terminates crises and restores hematologic balance

## IDIOPATHIC THROMBOCYTOPENIC PURPURA

Acute attacks may be treated by

1. Splenectomy
2. Hormones
- A. Splenectomy: life saving during crises
- B. Transfusions used freely
- C. Abnormal bleeding stops when splenic pedicle is clamped
- D. Splenectomy prevents or terminates
  1. Chronic invalidism
  2. Cerebral hemorrhage

*From Department of Medicine, Department of Pathology, Department of Radiology, The Grace-New Haven Community Hospital and the Yale University School of Medicine*



3. Retinal hemorrhage and blindness
4. Abnormal vaginal hemorrhage
- E. Splenectomy restores hematologic balance

#### SPLENIC NEUTROPENIA

- A. Splenectomy: life saving during crises
- B. Transfusions of little value
- C. Splenectomy terminates crises and restores hematologic balance

#### SPLENIC PANCYTOPENIA

- A. Splenectomy: life saving
- B. Splenectomy terminates crises and restores hematologic balance
- C. Transfusions valuable

### HYPERSPLENISM SURGICAL INDICATIONS

Primary Recurrent Hypersplenism may be expressed as:

- A. Congenital Hemolytic Anemia
- B. Idiopathic Thrombocytopenic Purpura
- C. Splenic Neutropenia
- D. Splenic Pancytopenia

The recurrence may follow the same pattern as the primary episode or another type of hypersplenism may follow. Thus cases of hemolytic anemia may be followed by thrombocytopenia or vice versa.

Recurrences may be due to:

- A. Generalized reticulo-endotheliosis (does not yield to surgery)
- B. Implantation splenosis (does not yield to surgery)
- C. Accessory spleens which are not removed at the primary operation may grow and cause recurrent hypersplenism. These accessory spleens have been visualized with thorotrast and removal surgically has terminated the hypersplenic episode and resulted in cure.

#### SECONDARY

In the course of many chronic diseases an acute life-threatening episode of hypersplenism of the secondary type may occur. Removal of the spleen terminates the hypersplenic episode and the primary disease follows its usual chronic course.

Hypersplenism of this type may be expressed as:

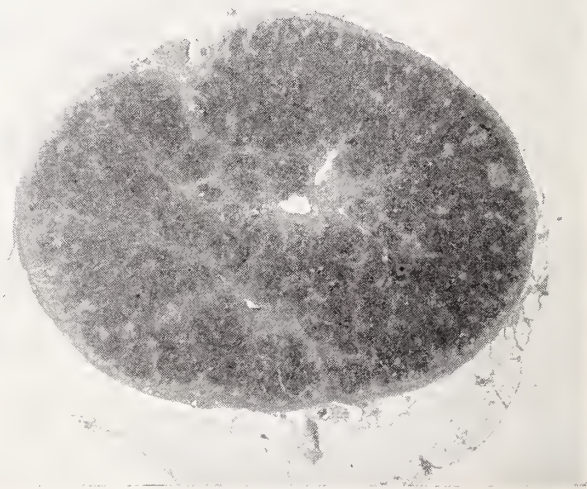
- A. Acquired Hemolytic Anemia.
- B. Thombocytopenic Purpura.
- C. Splenic Neutropenia.
- D. Pancytopenia.

The purpose of this report is to demonstrate the relationships among the diseases which are hypersplenic in origin and to make clear the advantages which may be derived from surgical removal of the spleen.

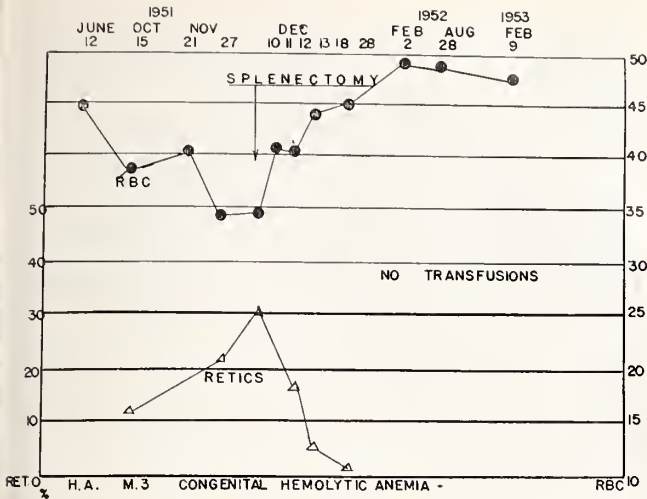
The charts explain in outline the interrelationship of primary, recurrent and secondary hypersplenism and the expression of each in the peripheral blood. The three other charts give further detail of the three general types of hypersplenism and explain the results that may be expected from surgery.

There are sixteen case reports, each of which consists of a chart showing changes in the peripheral blood before and after splenectomy and transparencies of splenic tissue, gross pathology or x-ray studies. Each of these case reports contributes in some way to the general contention that in properly selected cases splenectomy cures, prevents or relieves the major symptoms and signs and restores the equilibrium caused by the hypersplenic disease or episode.

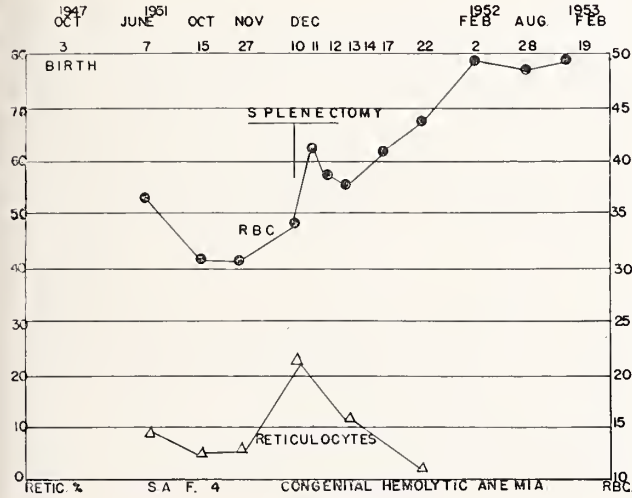
In the four cases of congenital hemolytic anemia, (two sets of brother and sister, HA, SA, GE, and JE) splenectomy in early life is thought to have restored normal hematologic equilibrium and to have reduced hearts dilated by chronic anemia to normal size. Chronic invalidism has been relieved, and it is thought that resistance to upper respiratory infection, and in one instance (GE) to meningococcus meningitis, has been greatly increased. All are well at present.



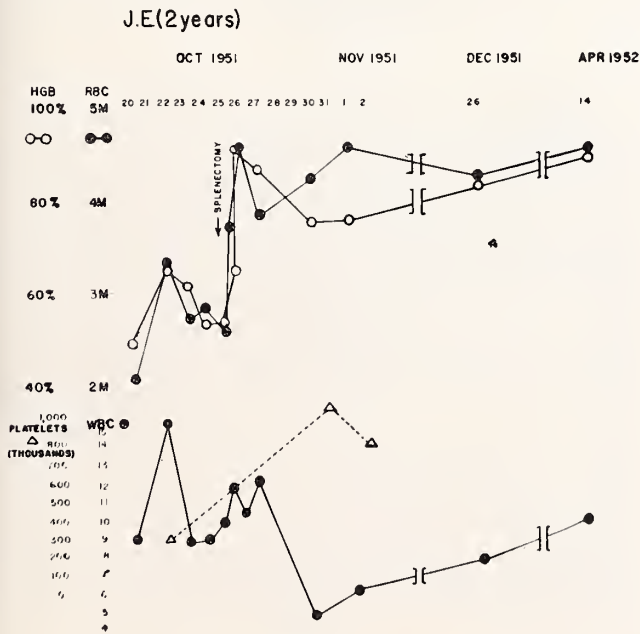
H. A. Case No. 1 Accessory spleen 3 cm. in diameter removed at original operation



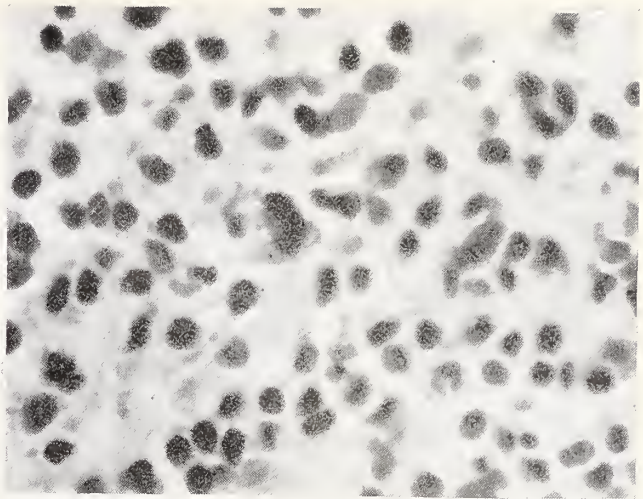
Case 1



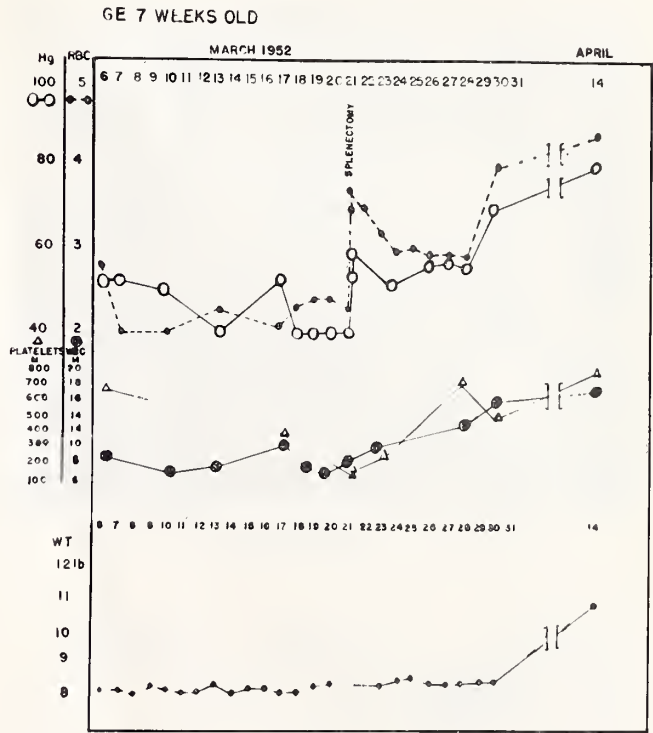
Case 2



Case 3



G. E. Case No. 4. Note macrophages with red cell inclusions



Case 4

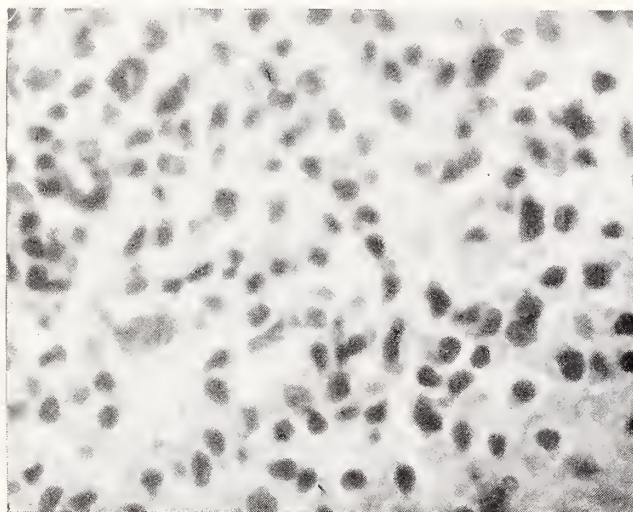
Case 5 (JPA) demonstrates cholelithiasis in a seventeen year old girl with congenital hemolytic anemia. Her hematologic balance was restored to normal, and she was able to combat successfully tuberculosis with cavitation and lobectomy. She is now well and is the mother of one healthy child.

Cases 6 (MG) and 7 (MR) had idiopathic thrombocytopenic purpura with hemorrhage into the eyegrounds. In case 6, operation was deferred in the hope that "conservative" measures would hold the disease in check. The patient is blind although

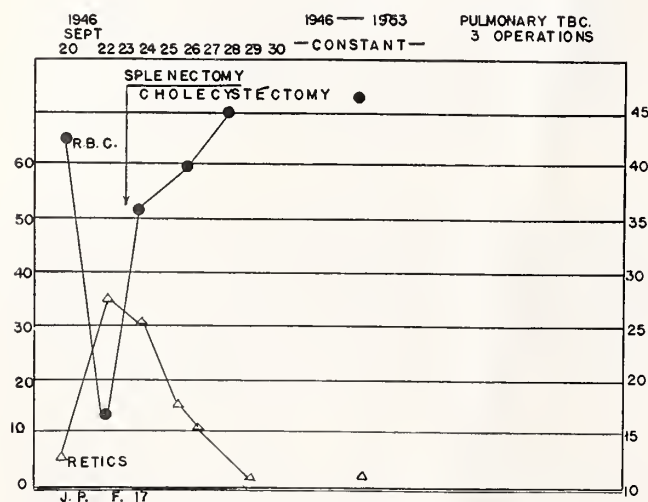




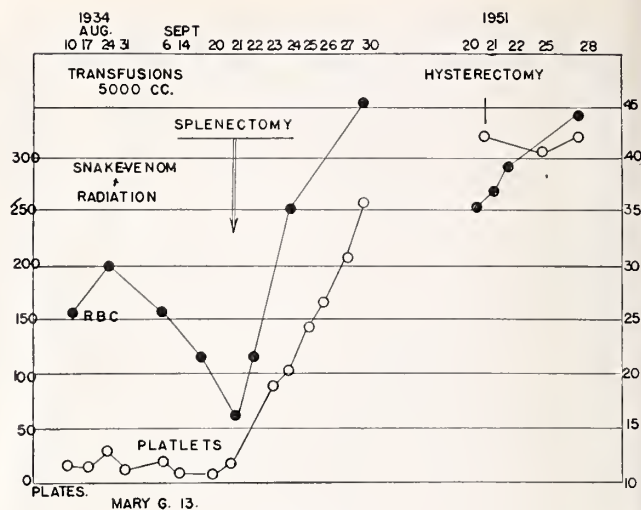
J.P.A. Case No. 5. Note gallstones. 17 year old girl



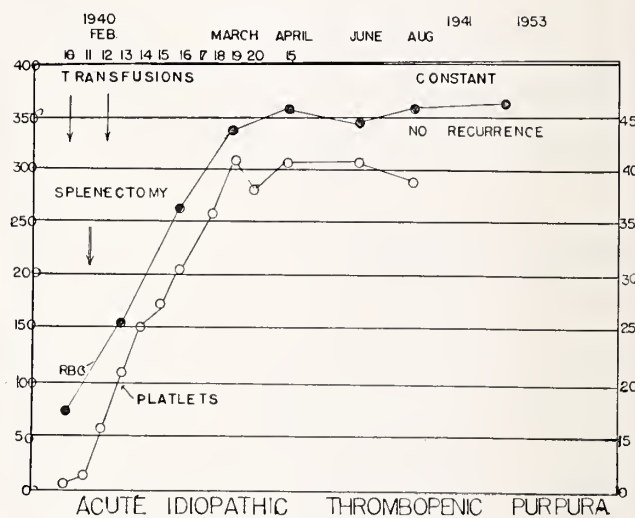
J.P. Case No. 5. Note macrophages with red cell inclusions



Case 5

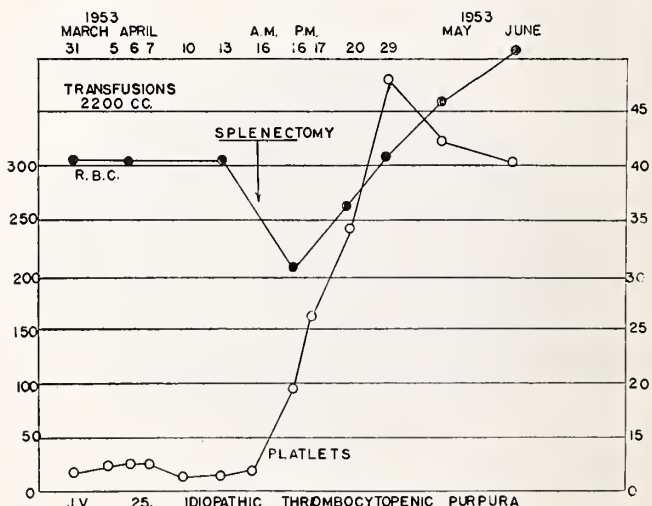


Case 6



MR-F-23yrs

Case 7



Case 8

splenectomy (after blindness had developed) cured the idiopathic thrombocytopenic purpura. In contrast, case 7 was operated on at once, and this patient has been well ever since. She has three healthy children born after splenectomy.

Case 8 (JV), idiopathic thrombocytopenic purpura, was operated after a period of observation of two years. The spleen in this case was crowded with platelets. Operation cured her disease.

Case 9 (PS) pancytopenia. Originally it was reported as hemolytic anemia, but it is obvious from the findings that all cellular elements were involved. She has been well without recurrence for over ten years.

Case 10 (ND) pancytopenia with slight reduction in all cells and platelets also. Response to splenectomy has been gratifying and complete. He is well at the end of 6 years. (Case seen with Dr. C. A. Doan.)

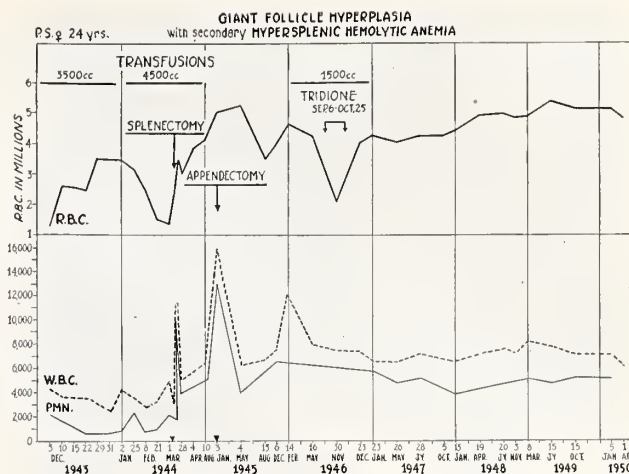
Case 11 (ET) acquired hemolytic anemia of unknown origin. After splenectomy the congestive heart failure with edema cleared along with restoration of hematologic equilibrium and without measures directed to heart disease. She is well at the end of 2 years.

Case 12 (CS) is one of acute hemolytic anemia complicating giant lymph follicle hyperplasia. Splenectomy restored hematologic equilibrium and she has been entirely well for four and one-half years.

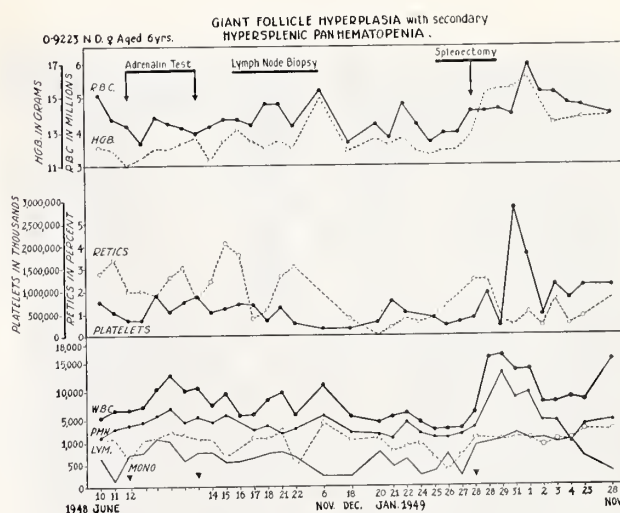
Case 13 (GH) is one of Gaucher's Disease complicated by fulminating thrombocytopenic purpura. Removal of a 5,000 Gm. spleen resulted in an enormous rise in the platelets, from 8,000 to 1,250,000 with maintenance of high platelet counts for 10 months.

Case 14 (RV) is one of primary recurrent hypersplenism due to implantation splenosis. An episode of idiopathic thrombocytopenic purpura was briefly relieved by splenectomy. In removing the major spleen, large amounts of splenic pulp were spilled in the peritoneum. At reoperation and at postmortem much implanted splenic tissue was found. This patient displayed both recurrent idiopathic thrombocytopenic purpura and hemolytic anemia before her death.

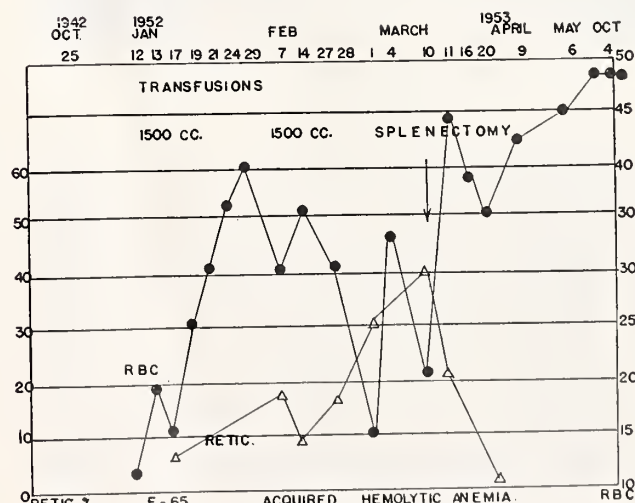
Case 15 (EK) is one of recurrent primary congenital hemolytic anemia in whom removal of a primary spleen caused a remission of one year. Recurrence of hemolytic anemia was found to be due to an accessory spleen visualized several years



Case 9



Case 10

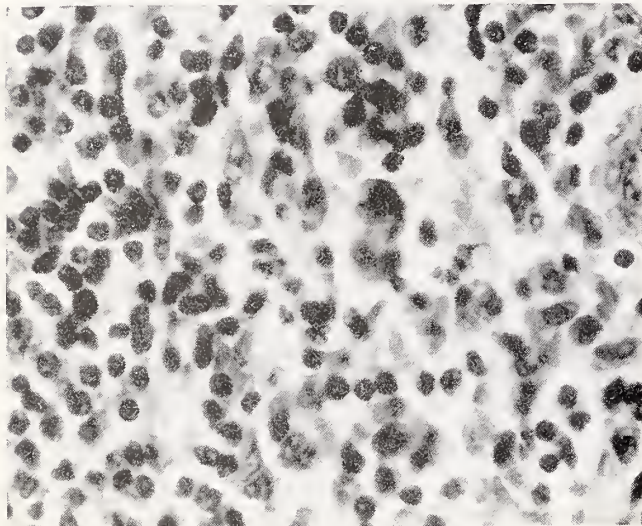


Case 11

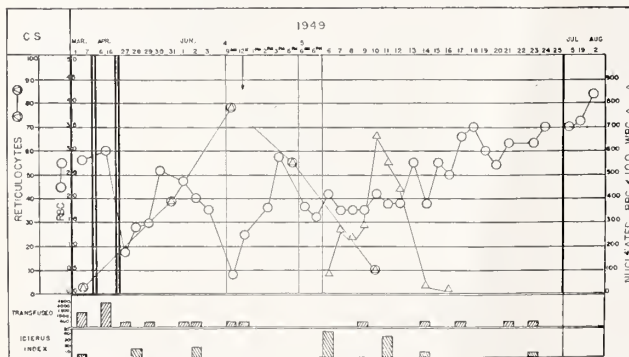




E. T. Case No. 11. Note infiltration of spleen with iron



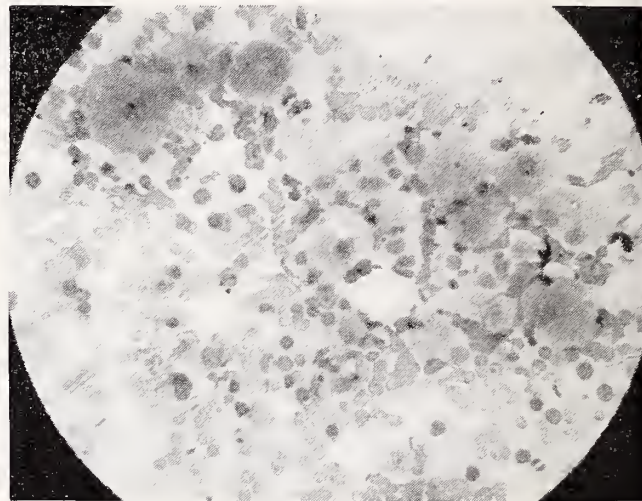
C. S. Case No. 12. Note macrophages with red cell inclusions



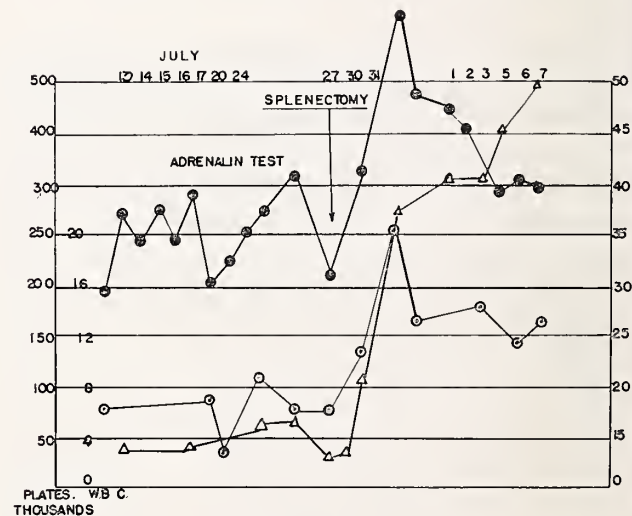
Case 12



G. H. Case No. 13. Spleen. Weight— Gaucher's Disease, Secondary Thrombocytopenic Purpura



G. H. Case No. 13. Spleen, high power. Note large number of entrapped platelets. Gaucher's Disease, Secondary Thrombocytopenic Purpura



Case 13



ago. The patient has refused reoperation and has continued to have profound anemia of the hemolytic type and episodes of congestive heart failure due to dilatation of the heart.

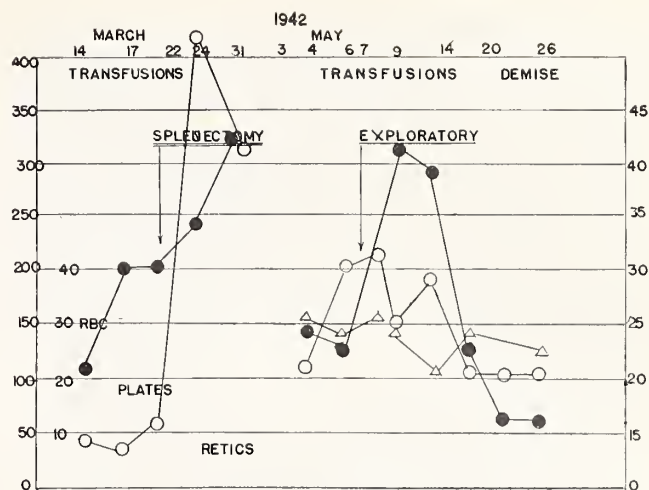
Case 16 (RM) is one of recurrent primary hypersplenism of the idiopathic thrombocytopenic type who had a major spleen removed. She had a remission of several years. Idiopathic thrombocytopenic purpura developed again and a 50 Gm. accessory spleen was removed with cessation of all signs and symptoms.

#### HISTORY

The term "hypersplenism" seems to have been first suggested by King<sup>1</sup> in 1914 after studies with Eppinger in these words: ". . . gross changes in the spleen are the dominating features of the clinical picture and yet there has been no attempt to correlate these changes in the spleen with the clinical picture. That this organ has a definite function can hardly be questioned. There is considerable evidence to show that the spleen may have marked influence on hemolysis. It is but a step to assume that there exist for the spleen conditions associated with hyperactivity of some of its functions—let us say the function of hemolysis. To such a condition the term "hypersplenism" may be applied. If it can be shown that important clinical symptoms consistently disappear or are strikingly mitigated when the spleen is removed from the body, an important step will have been taken toward defining the functions of the spleen." This quotation is a clear prophecy of what was to transpire in the near future for in 1916 Kaznelson,<sup>2</sup> either independently or with knowledge of King's hypothesis, suggested that the spleen of a patient with hemorrhagic purpura be removed. The operation was successfully accomplished and the patient made an uneventful recovery. The value of splenectomy was established and the operation has become the therapy of choice in most hematologic groups for a number of diseases. Since then studies of these syndromes have been carried out in a great many laboratories. With the space available it is not possible to mention every contributor, but Doan<sup>6</sup> and his co-workers and Dameshek<sup>10</sup> and his associates have made the term familiar to every practitioner of medicine.

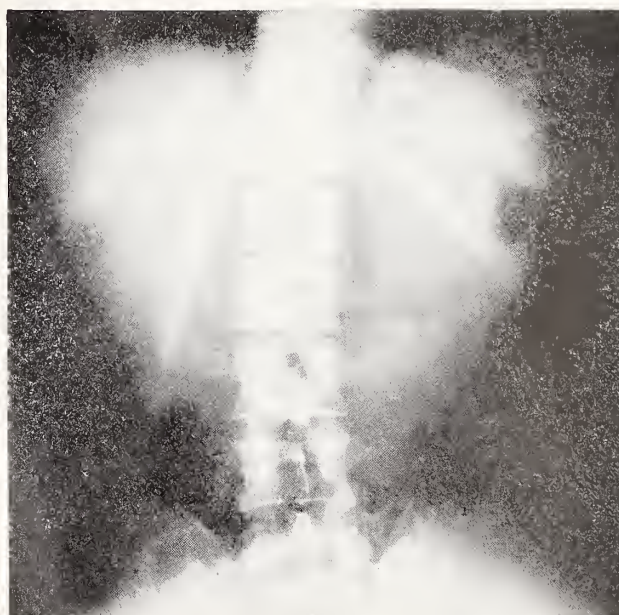
#### DEFINITION

We believe that the essential factor in the syndrome is the spleen, and that the bone marrow only



R.V.—F—54yrs.

Case 14



E. K. Case No. 15. Thorotrast visualization of accessory spleen

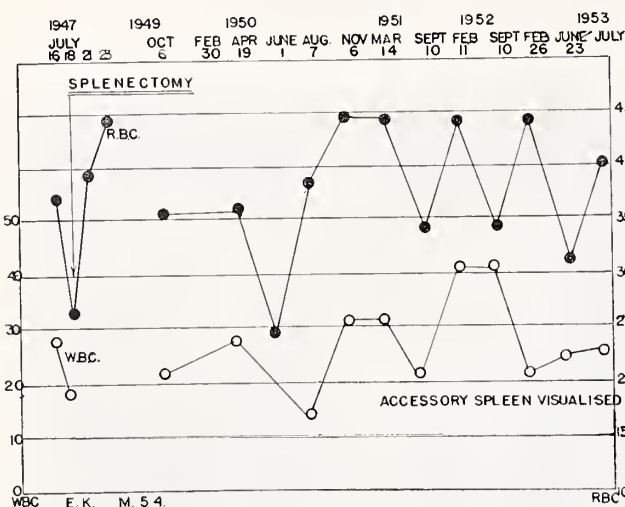
reflects what is happening in the spleen and in the peripheral blood. Therefore, we feel that the bone marrow must show hyperactivity in the production of those very elements which are deficient in the peripheral blood. In other words, in hemolytic icterus, though the peripheral blood is deficient in red blood cells, the bone marrow shows increased erythroid activity so that the M.-E. ratio is altered. In thrombocytopenia, although the platelets are deficient in the peripheral blood, there are more than



the usual number of megakaryocytes in the bone marrow. In neutropenia the myeloid elements of the bone marrow are hyperplastic, and in pancytopenia of splenic origin all elements are hyperactive. We further find that there is no evidence of "arrest" in any of the bone marrow elements and that "delivery block" is not present. Attempts should be made to determine the presence of any extra splenic immunohematologic factor, any allergic basis, or any drug hypersensitivity.

#### CRITERIA FOR THE DIAGNOSIS OF HYPERSPLENISM

- (1) Peripheral cytopenia.
- (2) Bone marrow hyperactive in those very elements deficient in the peripheral circulation.



Case 15

(3) No evidence of "arrest" or "delivery block" in the bone marrow.

(4) No evidence of extra splenic immuno-hematologic factors, allergy, or drug sensitization.

(5) No evidence of metaplasia in the spleen.

(6) Adrenalin test important if positive.

#### POST SPLENECTOMY

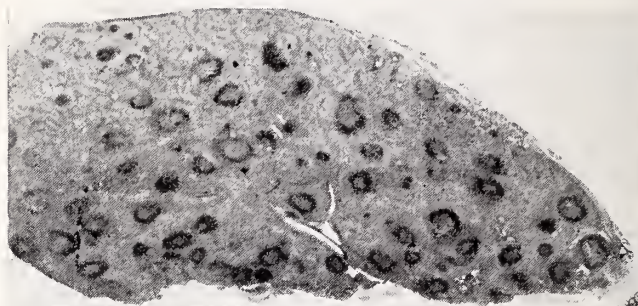
(7) Increased activity of macrophages in the spleen seen in "vital" preparations and stained smears of the pulp, rarely seen in fixed tissues.

(8) Restoration of hematologic balance if all splenic tissue is removed.

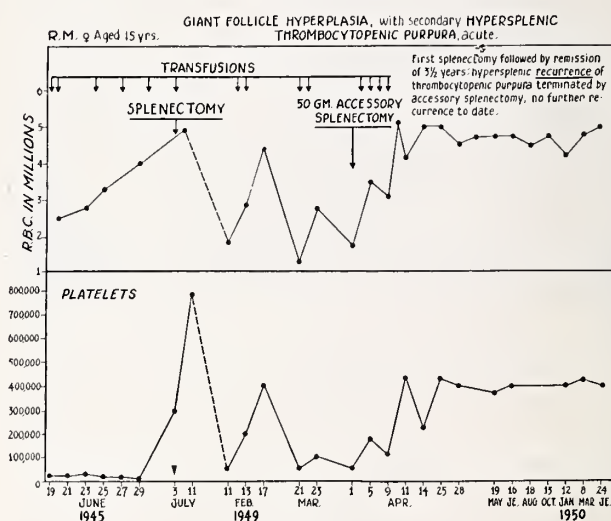
#### PHYSIOLOGY

By Bjorkman's<sup>3</sup> work the different points of view on splenic circulation have found a common denominator. Thus our present concept is that the

spleen has a semi-open circulation with contractile stomata acting as a filter mesh in the sinus walls. Under normal conditions this structure acts to allow separation of the plasma from the cellular elements of the blood and to concentrate these cells in the sinusoids. However, under abnormal conditions—such as simple congestion with increase in splenic size and in a variety of diseases—the stomata are stretched and allow the cellular elements to enter



R. M. Case No. 16. Accessory spleen. Note similarity in size and shape to normal spleen



Case 16

the pulp where a large standing army of reticulo-endothelial cells is waiting for action.

#### MECHANISMS

The mechanism, or mechanisms, by which the normal physiology of the spleen becomes distorted may be either inherited or "acquired." The precise details of the *modus operandi*, however, remain matters of conjecture, hypothesis and continuing experimentation.

Three major approaches are helping to further clarify current concepts: (1) The direct visualiza-

tion by transillumination of the splenic sinusoids, with indirect measurement of changes in the size of the interendothelial stomata which may govern the intra- versus extra-vascular splenic stasis—individual variation in storage of circulating blood elements, (Knisely,<sup>4</sup> Whipple et al.,<sup>5</sup> Bjorkman<sup>3</sup>); (2) the development of immuno-hematologic technics for demonstrating incomplete (“blocking”) or monovalent antibodies; and (3) further evidence as to the cellular sources of globulin antibodies.

#### PRIMARY HYPERSPLENISM

This is a condition in which there is a hyperinstability of the spleen, sometimes inherited as a Mendelian dominant gene factor as in hemolytic icterus and at others as a recessive character of infrequent expression. “Spontaneous” hypersplenic episodes may occur without demonstrable cause associated with such physiological states as pregnancy, or may be related to minor trauma and infections. Since these episodes may occur without warning, “splenectomy should be done when an unequivocal diagnosis of hypersplenism can be made.” (Doan.) An operation of election before a crisis has developed is done with greater ease and at less risk to the patient. However, “splenectomy should not be deferred in the event of a crisis since more patients’ lives are lost as a result of procrastination than as a result of action.” (Dameshek.)

Primary hypersplenism is exemplified in the following diseases:

- (1) Congenital or acquired hemolytic icterus.
- (2) Thrombocytopenic purpura.
- (3) Splenic neutropenia.
- (4) Panhematopenia.

Although each of the first three occur in pure form, it is usually found that some involvement of the correlative strain of cells is present. Thus in most cases of hemolytic icterus there is some evidence of purpura, and in splenic neutropenia there is some evidence of hemolysis.

#### SECONDARY HYPERSPLENISM

In the course of a number of diseases the spleen may become secondarily involved and if the predisposing factors necessary for the development of hypersplenism are present and are activated, this condition will manifest itself and will call for splenectomy. These instances are not very infrequent; thus in a series of 326 splenectomies during the years

1932-1949 Doan has classified 65 per cent as primary and 35 per cent as secondary.

Banti's disease .....	42
Felty's syndrome .....	6
Acquired hemolytic icterus.....	16
Gaucher's disease .....	4
Xanthochromatosis .....	1
Lymphatic leukemia .....	4
Myelocytic leukemia .....	2
Monocytic leukemia .....	1
Tuberculosis .....	3
Syphilis .....	2
Boecks' sarcoid .....	1
Hodgkins' .....	5
Reticulo sarcoma .....	1
Hemangioma .....	2
Multiple myeloma .....	1
Giant follicle lymphoma.....	6

#### HEMOCLASTIC CRISES

Because of the tendency for primary hypersplenic patients to go into crises, operation should be done as an elective procedure when possible. More frequently than not, however, the patient is first seen during a crisis, and under these circumstances, an immediate and life-saving splenectomy may have to be done. In all cases the bone marrow should be carefully studied, for unless this tissue is either normal or hyperactive, the disease is not of splenic origin and splenectomy will not cure the condition but will add materially to the risk of fatality. If the bone marrow is hyperactive and the other criteria for diagnosis of the disease are present, operation should not be delayed.

In the case of congenital or acquired hemolytic icterus we believe that splenectomy should be done as soon as the diagnosis is made. We also believe that transfusion is more apt to do more harm than good by causing hemolysis and acute renal failure and we therefore advocate that the patient undergo splenectomy before transfusion, and that the best results will be obtained when transfusion is delayed until splenectomy has been accomplished. This is not in accord with the opinion of many hematologists, but we should remember that: 1. These patients do not bleed. 2. That the spleen itself contains a large quantity of blood which will be poured into the circulation as soon as the organ is touched, and that this sequestered blood will act as a very large “auto”-transfusion. It is almost the rule that these patients leave the table with a higher blood count and blood volume than they have at the inception of the operation. We have often seen a rise of 1,000,000 red blood cells immediately following splenectomy.



TABLES SHOWING THE PERTINENT FINDINGS IN EACH TYPE OF HYPERSPLENISM

CONGENITAL HEMOLYTIC ANEMIA								
CASE		FAMILY HISTORY	HISTORY	PHYSICAL	LABORATORY	BONE	PATHOLOGY	REMARKS
INITIALS	NO.			EXAMINATION		MARROW		
H.A.	1	3 generations	Pallor	Pallor	Coombs:0	Hyperplasia	Spleen 106 gr.	No recurrence
3 years		Grandfather	Weakness	Dilated heart	Ind. Bilirubin	RBC	Sinusoids	3 years
		Father	Frequent	Splenomegaly	2.0 mgs.		empty	
		Sister	U.R.I. since birth		Platelets 400,000		Pulp RBC	
					Spherocytes		Phagocytes	
					Fragility 0.50:0.40		RBC	
					Rouleaux			
S.A.	2	3 generations	Pallor	Pallor	Coombs:0	Hyperplasia	Spleen 112 gr.	No recurrence
4 years		Grandfather	Weakness	Dilated heart	Ind. Bilirubin	RBC	Sinusoids	3 years
		Father	Frequent	Splenomegaly	3.0 mgs.		empty	
		Brother	U.R.I. since birth		Platelets 750,000		Pulp RBC	
					Spherocytes		Phagocytes	
					Fragility .052:46		RBC	
					Rouleaux		No pigment	
J.E.	3	3 generations	Pallor	Pallor	Coombs:0	Hyperplasia	Spleen 90 gr.	No recurrence
2 years		Grandfather	Weakness	Dilated heart	Ind. Bilirubin	RBC	Sinusoids	3 years
		Father	Frequent	Splenomegaly	4.0 mgs.		empty	
		Sister	U.R.I. since birth		Platelets 500,000		Pulp RBC	
					Spherocytes		No pigment	
					Fragility .54:4.4			
					Rouleaux			
G.E.	4	3 generations	Pallor	Pallor	Coombs:0	Hyperplasia	Spleen 60 gr.	No recurrence
7 weeks		Grandfather	weakness	Splenomegaly	Ind. Bilirubin	RBC	Sinusoids	3 years
		Father	since birth		2.5 mgs.		empty	Acute meningo-
		Brother			Platelets 450,000		Pulp RBC	cocci septicemia
					Spherocytes		No pigment	6 months after
					Fragility .052:46			splenectomy
					Rouleaux			
J.P.	5	3 generations	Pallor	Pallor	Coombs:0	Hyperplasia	Spleen 700 gr.	T.B. cavity
17 years		Grandmother	Weakness	Splenomegaly	Ind. Bilirubin	RBC	Sinusoids	Lobectomy 6
		Aunt	Abdominal	Gall stones	5.6 mgs.		empty	months after
		Brother	pain since birth	Jaundice	Platelets 500,000		Pulp RBC	splenectomy
					Spherocytes		Phagocytes	1 healthy child
					Fragility .060:0.048		RBC	No recurrence
					Rouleaux		No pigment	7 years
IDIOPATHIC THROMBOCYTOPENIC PURPURA								
M.G.	6	Hemorrhage nose, skin, mouth	Hemorrhage eye-grounds, skin, mucous membranes	Bleeding time: 14 min. Clotting time: 12 min. Clot retraction none in 48 hours	Not done		Spleen 125 gr. Platelets Macrophages	Total blindness 17 years after splenectomy Hysterectomy, fibroids No recurrence of I.T.P.
		Blindness—3 months						
M.R.	7	Hemorrhage skin, vaginal 3 days	Vaginal hemorrhage Tubal hemorrhage Hemorrhage eye-grounds	Bleeding time: 10 min. Clotting time: 14 min. Clot retraction none in 48 hours	"Resting" and active megakaryocytes		Spleen 200 gr. Platelets Macrophages R. Tubal pregnancy	700 cc. blood in abdominal cavity from right tube 3 children since splenectomy No recurrence
J.V.	8	Recurrent hemorrhage skin, vaginal, 2 years	Vaginal and skin hemorrhage	Bleeding time: 10 min. Clot retraction none in 48 hours	"Resting" and active megakaryocytes		Spleen 300 gr. Platelets Macrophages	300 cc. of incompatible blood at operation No severe symptoms
PANCYTOPENIA SECONDARY TO GIANT LYMPH FOLLICLE HYPERPLASIA								
P.S.	9	Recurrent hemolytic episodes with neutropenia and thrombopenia probably since birth	Hepato-splenomegaly Pallor Icterus	Ind. Bilirubin 5 mg. Platelets 60,000 Neutrophils 3,000 Spherocytes Reticulocytes Fragility 0.58:0.44	Marked hyperplasia RBC Moderate WBC and megakaryocytes		Spleen 1000 gr. Sinusoids empty Pulp filled with RBC Phagocytosis	Appendectomy 13 years No recurrence hemolytic anemia due to Tridione

CASE INITIALS NO.	HISTORY	PHYSICAL EXAMINATION	LABORATORY	BONE MARROW	PATHOLOGY	REMARKS
PANCYTOPENIA						
N.D. 10 6 years	Recurrent infections Hemorrhage from bowel	Splenomegaly Lymph adenopathy		Hyperplasia of all bone marrow elements	Spleen Phagocytosis of RBC	No recurrence in 6 years
"PRIMARY" ACQUIRED ANEMIA						
E.T. 11 56 years	Dyspnoea Edema Weakness 2 years	Dyspnoea Edema Pallor	Coombs: Positive Ind. Bilirubin 7mgs. Fragility 5.8:4.2 Spherocytes Platelets 500,000 Fecal Urobilinogen 1111 500 mg.	Hyperplasia RBC and granulocytes	520 Gm. spleen Sinusoids empty Pulp filled RBC Phagocytosis	Congestive failure relieved No digitalis Well after four years No recurrence
SECONDARY ACQUIRED HEMOLYTIC ANEMIA						
C.S. 12 47 years	Pallor Weakness Jaundice Biopsy 5 years before—Giant Follicle Hyperplasia	Pallor Weakness Jaundice Splenomegaly Hepatomegaly R. Axillary lymph adenopathy	Coombs: Positive Ind. Bilirubin 6.7mgs. Platelets 500,000 Fecal urobilinogen 450 mg. Fragility 6.8:45	Hyperplasia RBC and granulocytes	Spleen 1000 gr. Sinusoids empty Pulp filled RBC Phagocytosis Giant lymph follicle hyperplasia	No recurrence 5 years Thyroidectomy 1953 Pneumonia 1954
SECONDARY THROMBOCYTOPENIC PURPURA						
G.H. 13	Primary disease Gaucher's disease since birth Recent skin and mucous membrane hemorrhage	Pallor Weakness Splenomegaly Hip joint disease	Clotting time: 12 min. Clot retraction none in 48 hours Bleeding time: 7 min.	"Resting" and active megakaryocytes Gaucher's cells	Spleen Pulp filled with platelets Phagocytosis Gaucher's cells	Arthritis improved No recurrence 1 year
PRIMARY RECURRENT HYPERSPLENISM						
IDIOPATHIC THROMBOCYTOPENIC PURPURA FOLLOWED BY HEMOLYTIC ANEMIA DUE TO IMPLANTATION SPLENOSIS						
R.V. 14 57 years	Hemorrhage skin, vaginal, bowel	Splenomegaly Petachiae Later jaundice and pallor	Coombs: Positive Platelets 30,000 Fragility 5.4:44 Reticulocytes 30% Clot retraction none in 48 hours	Hyperlasia RBC "Resting" megakaryocytes	Spleen 400 gr. Phagocytosis	(1) Thrombocytopenia (2) Hemolytic anemia Death due to implantation splenosis
CONGENITAL HEMOLYTIC ANEMIA DUE TO ACCESSORY SPLEEN						
E.K. 15 54 years	Family history—daughter jaundice	Splenomegaly Icterus Hepatomegaly Large heart Visualized accessory spleen	Coombs:0 Platelets 450,000 Fragility 5.8:4.6 Reticulocytes 24% Nucleated RBC post-splenectomy	Hyperplasia RBC	Spleen 500 gr. Phagocytosis	No symptoms 1 year post-splenectomy Then recurrence all signs and symptoms Refused second splenectomy Thorotrast visualized accessory spleen 4 cm. diameter
IDIOPATHIC THROMBOCYTOPENIC PURPURA DUE TO ACCESSORY SPLEEN						
R.M. 16 14 years	2 cousins leukemia Skin and vaginal hemorrhage prior to each operation	Severe vaginal hemorrhage "shock" Petechiae	Bleeding time: 6 min. Clot retraction none in 48 hours	"Resting" and active megakaryocytes	Spleen 150 gr. Accessory spleen 50 gr. Trapped platelets Phagocytes 111	(1944) Remission (1949) Recurrence 50 gr. accessory spleen removed 1949-1954 no recurrence



In the case of purpura, on the other hand, transfusion should be given before and after operation. In these cases the amount of retained blood is small for the spleens rarely weigh much over 250 Gm., and in addition there is a severe bleeding tendency. While bleeding stops very dramatically as soon as the pedicle is clamped, blood loss may already have been so severe that 5 or 6 pints of bloods will be needed.

In the cases of splenic neutropenia and pancytopenia, transfusion is likewise essential.

#### RECURRENT HYPERSPLENISM

When in a case of hypersplenism the spleen has been removed with the resultant remission of several weeks, months or years, and the same or a different expression of hypersplenism arises, one should be suspicious of the presence of an accessory spleen, generalized reticuloendotheliosis or implantation splenosis.

(1) Ross<sup>8</sup> called attention to the possibility that removal of a hyperactive spleen during the course of hypersplenism might conceivably act as a stimulus causing hyperactivity of all of the remaining reticuloendothelial structures, particularly the lymph nodes, liver and even the bone marrow. She described a case in which this sequence of events occurred, and the same condition has been described by Doan and Wiseman<sup>7</sup> and their co-workers. Fortunately this sort of episode rarely occurs.

(2) Curtis<sup>9</sup> referred to a second group of cases as "implantation splenosis." He described several instances in which rupture of the spleen and escape of splenic tissue into the abdominal cavity apparently resulted in implantation and growth of many small spleens imbedded in the peritoneum. If these splenic implants have the same elements of hyperactivity as the original spleen, they produce recurrent hypersplenism. He called attention to the necessity for obviating such a catastrophe. This type of episode is also rare.

(3) The occurrence of accessory spleens is quite common. Frequently when the major spleen is removed, a small accessory spleen is found in the pedicle of the major spleen or in the area near the spleen. Rarely accessory spleens have been found in all portions of the abdomen and even in the ovaries

and testicles. It is therefore important that a search for accessory spleens be carefully made at the original operation. A careful search at this time is not always possible, due to the exigencies of the operation. A number of cases have been reported where accessory spleens have been found at post-mortem. Approximately 12 cases have been found at second operation or by the use of thorotrast. In at least 7 cases removal of the accessory spleen has resulted in remission of the recurrent hypersplenism. While this is a small group, there are probably more cases in which such a possibility is overlooked, and since it is possible to terminate a potentially fatal crisis by removal of an accessory spleen, it is very important to consider this possibility.

The following members from the Hematology Clinic and the Pathological Service aided in the preparation of this work: A. Cipriano, M.D., P. Piccolo, M.D., S. Spinner, M.D., M. Swirsky, M.D., R. White, M.D., and W. McAllister, M.D.

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# CARCINOMA IN SITU OF THE CERVIX

## A Review Including 31 New Cases at Bridgeport Hospital

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### DEFINITION

Synonyms for carcinoma in situ of the cervix include the following terms: Noninvasive potential carcinoma, Bowen's disease of the cervix, incipient carcinoma of the cervix, preinvasive carcinoma of the cervix, superficial noninvasive intraepithelial carcinoma of the cervix and intraepithelial carcinoma of the cervix.<sup>26</sup> Carcinoma in situ may be described as consisting of a completely undifferentiated squamous epithelium which forms an intact layer of cells covering the portio vaginalis of the cervix, and which can extend to the vagina or into the cervical glands. A sharp demarcation is always noted between the normal tissue and the malignant epithelium, and no evidence of connective tissue invasion is seen.

### HISTORY

Rubin<sup>19</sup> first described two cases of carcinoma in situ in 1910. He called these cases "incipient carcinoma." Schottlaender and Kermauner<sup>23</sup> described a surface coating of malignant epithelium at the periphery of invasive carcinoma of the cervix in 1912. This apparently referred to the carcinoma in situ-like pattern which is seen at the borders of invasive carcinoma. Cullin in 1921<sup>9</sup> published a report of unsuspected early carcinoma of the cervix. However, Broders<sup>6</sup> was the first to use the term carcinoma in situ in 1932. It may be noted that, despite this long history, the importance of carcinoma in situ was not generally recognized until the Papanicolaou technique came into general use after World War II.

### PATHOGENESIS

The major question which has troubled pathologists through the years regarding carcinoma in situ has been whether it consists of a preinvasive malignancy or whether it is a separate entity entirely. Thus work has been done in order to judge whether it occurs at a rate consistent with the incidence of frank cancer of the cervix, and whether or not it is an irreversible process. Regarding the latter question,

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### SUMMARY

The question as to whether carcinoma in situ is a preinvasive malignancy or entirely a separate entity has troubled pathologists for many years. An attempt has been made by this author to correlate the various theories concerning the pathology and etiology of this lesion, and to compare the types of treatment now in use. The 31 cases reviewed from the Bridgeport Hospital are fairly typical as to diagnosis, symptomatology and method of treatment.

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eighteen cases have been gleaned from the literature<sup>22</sup> where carcinoma in situ had been untreated and had then progressed into invasive carcinoma of the cervix. A deliberate experiment with close observation was carried out on a patient in 1937 who was proven to have carcinoma in situ. This patient was found to have developed a small squamous carcinoma of the cervix with stromal invasion eleven months after the diagnosis of carcinoma in situ was made. In this particular case the cervix was amputated and the patient has had no recurrence.<sup>26</sup>

The average age of women affected by carcinoma in situ was found to be 38.7 years by Pund and Auerbach.<sup>18</sup> They compared this age with a large series of frank carcinoma of the cervix whose average age was 48 years. Their conclusions were that the incidence of carcinoma in situ was consistent with, if slightly less frequent than, the incidence of invasive carcinoma. It may also be noted at this point that invasive carcinoma of the cervix almost always shows a carcinoma in situ-like pattern of the surface epithelium at the periphery.

However, on the other hand a number of cases have been described of carcinoma in situ which had regressed spontaneously and disappeared.<sup>8,26</sup> None of these cases though have actually been documented.



## ETIOLOGY

Various conflicting theories have been developed regarding the etiology of carcinoma in situ. Two major theories have been presented, one of which has been strongly advocated by Ernest Ayre.<sup>2,3</sup> He has written extensively regarding the changes in morphology of the cervix caused by an increase in the circulating estrogens. Ayre reasons that a deficiency in thiamine causes an increase in estrogens to appear, since the liver which is impaired by a dietary deficiency of the vitamin B group will not inactivate as much of the circulating estrogens as will a normal liver. In the group of experiments used in proving this theory, urinary excretions of three fractions, estradiol, estrone, and estriol were measured (blood estrogen level studies were not done since they are still considered inaccurate).<sup>25</sup> A definite correlation was discovered between the amount of vaginal cornification and the amount of circulating estrogen, the endometrium becoming hyperplastic as well, and the cervix reacting to the estrogen hormones as did the vagina. Thus it may be seen that an increase in the amount of circulating estrogen, caused for one reason or another, can easily affect and change the surface epithelium of the cervix. A series of experiments on animals demonstrating the estrual changes taking place because of deficient nutrition was done by Biskind and Biskind.<sup>5</sup>

In a series of one hundred cases showing signs of cervical malignancy at McGill University, 86 per cent of the patients were noted to have a low thiamine excretion while 36 per cent had a low riboflavin excretion as well. Many of these patients were people who had been dieting for a long period of time and were thus subject to a thiamine deficiency. It must be stated, however, that about ten per cent of the control cases, with no evidence of malignancy, were found to have low thiamine excretion rates as well.<sup>3</sup>

Apparently malignant and embryonic cells seem to have the same enzyme patterns. It is conceivable that deficient vitamin supply to certain cells will result in these cells retaining some of their embryonic characteristics, especially in regards to the enzyme systems. Experimental work done by Burk, Greenstein and Thompson<sup>7,13</sup> demonstrated that embryonic and malignant hepatic tissues exhibit a deficiency in riboflavin as compared with normal tissue. Kensler and his associates<sup>15</sup> have shown that p-dimethyl aminoazobenzene which has been used to produce liver cancer in animals may have its effects

nullified by large amounts of riboflavin. Apparently the effect of this carcinogenic agent is to interfere with the enzyme system in which coenzyme I is involved, and coenzyme I is known to be unable to function properly without riboflavin.<sup>4</sup>

Another theory which has many exponents is that carcinoma of the cervix is closely correlated to chronic infection and inflammation of the cervix. According to Scapier,<sup>20</sup> both carcinoma in situ of the cervix and invasive carcinoma of the cervix are  $\frac{1}{5}$  to  $\frac{1}{6}$  as frequent in Jewish women as they are in other members of the population. This may be due to the fact that all Jewish men are circumcised, thus generally eliminating the smegma bacillus.

Gagnon at Quebec feels that chronic cervicitis is very important in the etiology of malignancy of the cervix and therefore must always be treated promptly. The major part of his work has been done with Catholic nuns who are not subject to the usual causes of cervicitis because of their social status. An annual survey of 3,000 nuns was made over a twenty-year period. This, according to Dr. Gagnon, represented an unchanging population of 65,000 people. Work was done with especial reference to the frequency of carcinoma of the cervix as correlated with the frequency of carcinoma of the uterus. This ratio according to Novak<sup>17</sup> is 7:1. Dr. Gagnon discovered fourteen cases of carcinoma of the uterus and no cases of carcinoma of the cervix. He used the ratio of 6:1 and felt that he should have discovered 72 cases of carcinoma of the cervix were he dealing with an average population. When a check survey was made by the Montreal Radium Institute and the various pathology laboratories, nineteen cases of uterine carcinoma were discovered as compared with three cases of cervical cancer (114 cases of cervical malignancy should have been discovered using the above criteria). Dr. Gagnon's conclusions were that chronic cervicitis which is encountered in many socially-free women is extremely important in the etiology of carcinoma of the cervix. He explained that these people may have had chronic cervicitis without intercourse. He believes that if chronic cervicitis is treated promptly, carcinoma of the cervix will almost never be encountered, and he quotes his own series of 4,000 cases in which such treatment was instituted without one case of carcinoma following.

TeLinde<sup>24</sup> and Schiller<sup>22</sup> feel, however, that chronic cervicitis is very often secondary to the appearance of the carcinoma, and Craig presents a series

of 2,895 cases of cervicitis which he has examined and treated and among which he found no cases of carcinoma.

#### **PATHOLOGY**

The minimal differences between the histological picture of frank invasive carcinoma of the cervix and that of carcinoma in situ have often been a source of controversy between pathologists. The major question seems to be to decide when a tissue is malignant and when it is benign. Abnormal cellular activity which eventually results in carcinoma begins in the basal cells of the surface epithelium. In the normal cervical epithelium a single layer of plump spindle cells which form the basal layer and which stain deeply with hematoxylin is seen. Carcinoma in situ usually begins with a slight overactivity of the basal layer of cells. This continues until the entire thickness of the epithelium is involved with these hyperactive cells. The cells and nuclei are seen to be irregular in size and shape with a variable number of mitotic figures present. After the entire thickness of the epithelium is involved, there is usually invasion of the cervical glands with destruction of the columnar cells. This may lead eventually to complete replacement of the gland by carcinoma in situ, the next step being frank invasion. Of considerable clinical interest is the time element involved between the first changes in the basal layer and the appearance of frank invasive carcinoma. In the various series of cases reported, the average age of patients suffering from carcinoma in situ was generally found to be nine to ten years younger than those suffering from frank invasive carcinoma.<sup>14</sup>

In a series done at the Boston Free Hospital for Women only 6 per cent of all patients suffering from carcinoma in situ were seen to have gross pathological lesions. These are listed in order of their frequency:<sup>26</sup>

1. Laceration with eversion of the cervix.
2. Erosion of the cervix.
3. Hypertrophy with erosion of the cervix.
4. Easily bleeding erosion.
5. Leucoplakia.
6. Cervical polyps.

Microscopically, the following criteria should be used in attempting an early diagnosis of carcinoma in situ of the cervix:<sup>24</sup>

1. Hyperchromatic oval nuclei (always present but in varying degree).

2. Decreased amount of cytoplasm in the epithelial cells.

3. Development of a thickened basal layer.

4. Occasional mitoses.

5. Leucoplakia occasionally present.

6. Intact basement membrane (differentiation between invasive and noninvasive carcinoma of the cervix).

7. Occasional sharp demarcation between carcinomatous tissue and normal tissue.

8. Lymphocytic infiltration in the stroma under the lesion.

9. Increase in the number of cells of the stratum germinativum of the epithelium as a whole.

10. Loss of polarity of the cells.

#### **DIAGNOSIS**

Various tests are available for the diagnosis of carcinoma of the cervix. Each of these tests have certain advantages and disadvantages as regards reliability, availability and comfort to the patient. The Schiller test may be mentioned although it is not in general use today. This test consists of a Gram-iodine stain which is applied directly to the cervical tissue. Only glycogen-containing tissue will react to this stain, and since carcinomatous tissue contains usually only a very limited amount of glycogen, it will generally remain unstained. However, leucoplakia or paraleucokeratosis will not take the stain as well, and it has been estimated that approximately ninety to ninety-five per cent of all positive Schiller tests are due to paraleucokeratosis.<sup>26</sup> The Schiller test is still used by a few for delineating the boundaries of proven carcinoma in situ in order to indicate the amount of vagina which is to be removed.

Vaginal smears, cervical smears and positive cervical scrapings are being used with increasing frequency today. In a series done at the Boston Free Hospital for Women, 70 per cent of patients who had proven carcinoma of the cervix showed malignant cells in vaginal and cervical smears. Upon review it was found that 87 per cent of the cases were found to be positive.<sup>14</sup> This approaches the 98 per cent positive findings of Achenbach, Johnstone and Hertig.<sup>1</sup> Ayre feels that the best approach is through positive cervical scrapings which he claims are 93 per cent accurate. It was felt by Younge, Hertig and Armstrong<sup>26</sup> that the greatest accuracy is achieved by the use of vaginal smears only after



the glands and stroma have been invaded. The stain in general use is the Papanicolaou preparation which colors malignant cell nuclei much more darkly than those of the normal cells. It may be noted that approximately fifteen hundred vaginal and cervical smears were examined at the Bridgeport Hospital in 1953. These smears were from both outpatient and inpatient sources and were all prepared by the Papanicolaou method. About twelve cases of all those examined were found to be positive.

Foraker<sup>11</sup> has used photoelectric methods in order to diagnose malignancy. He has demonstrated that both invasive and intraepithelial carcinoma of the cervix have identical light-absorbing qualities.

The best method for actual diagnosis is a direct biopsy of the lesion with microscopic examination of the tissue involved. In case of a small lesion, careful and multiple biopsy specimens must be taken covering the entire circumference of the portio vaginalis and the endocervical canal. Otherwise it is extremely easy to miss any evidence of malignancy. It might be interesting to note that 27 cases were examined carefully at the Memorial Hospital in New York as regards distribution of the lesions. Twenty of the specimens were whole uteri while 7 consisted of material obtained from trachelectomies. In 14 cases evidence of the disease was discovered on the portio vaginalis and within the endocervical canal. In 10 cases the lesion was limited solely to the portio vaginalis, while in the remaining three cases malignant tissue was found only in the endocervical canal. It was discovered impossible to judge the extent of the disease or its exact location with the naked eye, and direct palpation was found to be no help either. Since all lesions were concentrated at or about the external os, it was concluded that if material were taken for biopsy from the central junctional area of both the anterior and posterior lips as well as from the lateral angles of the external os, the great majority of positive lesions could be demonstrated.<sup>8,10</sup>

#### SYMPTOMATOLOGY

The symptoms of carcinoma in situ of the cervix are extremely variable and nonspecific. Of the series done at the Boston Free Hospital for Women, 46 per cent of the patients found to have carcinoma in situ had no complaints at all referable to the cervix.<sup>26</sup> The remainder either complained of leucorrhea or of abnormal bleeding in variable amounts. Suffice it to say that the slightest suspicion of any

pathology in the cervix should result in the necessary diagnostic procedures being used as soon as possible.

#### FREQUENCY OF OCCURRENCE

A number of statistical series have been published regarding the percentage of women affected with carcinoma in situ. All these series demonstrate that carcinoma in situ of the cervix is extremely frequent in its incidence, and must constantly be thought of during the examination of any mature women patients. Pund and Auerbach<sup>18</sup> describe a series of 1,200 clinically benign cervixes which had been examined after hysterectomy. Of these cervixes, 3.9 per cent were found to have carcinoma in situ. In another study at the Boston Free Hospital for Women in 1946, 1.15 per cent of all clinically diseased cervixes from which biopsy specimens were taken were discovered to have carcinoma in situ, whereas 0.84 per cent of the 2,262 cervixes and biopsies of all sorts examined that year were found to be positive. Their average over a twelve year period for all ambulatory patients was 1.2 per cent.

#### TREATMENT

In work done at the Boston Free Hospital for Women<sup>26</sup> it was discovered that if the cervix is adequately cauterized in its entire circumference about 85 per cent of the patients in whom only surface involvement was found will have no recurrence. This figure may be compared with 37 per cent who had no recurrence after cauterization even though they showed signs of gland and stroma involvement.

Patients who are treated with radium and radiation generally do very well with almost no recurrences being reported. However, if this method of treatment is employed, the complications of irradiation must be considered and patients are generally made sterile an average of ten years before their time. Most patients who are found to have carcinoma in situ are generally treated by total hysterectomy. The results of this method are excellent with recurrence and metastasis being extremely rare. Either the vaginal or abdominal approach may be used but it must always be remembered that carcinoma in situ can extend along the vagina, and therefore a vaginal cuff should be removed as well.

#### PROGNOSIS

Younge, Hertig and Armstrong<sup>26</sup> have gathered eighteen cases from the literature where carcinoma in situ was left untreated for one reason or another and eventually progressed into frank carcinoma of

the cervix. They also described a deliberate experiment of close observation which was carried out on a patient who was known to have carcinoma in situ in 1937. After eleven months the lesion was shown to develop into a small squamous cell carcinoma with invasion of the stroma. The cervix was amputated and the patient has been well since then. As was noted before, a few cases of minimal involvement have been reported where regression of the lesion took place despite positive vaginal smears. However, many pathologists have questioned the accuracy of the original diagnosis in these cases.

Younge and Hertig found that the time element involved in those cases which were observed to progress to frank carcinoma was anywhere from eleven months to thirteen years.<sup>14,26</sup>

#### 31 CASES OF CARCINOMA IN SITU AT THE BRIDGEPORT HOSPITAL FROM 1946 TO 1953

Of the thirty-six cases which were diagnosed as carcinoma in situ at the Bridgeport Hospital, careful restudy of the pathological specimens caused us to withdraw five cases from our series. We felt that these cases do not represent true carcinoma in situ but rather invasive carcinoma or simple metaplasia of the cervical epithelium. Our final results were therefore based on thirty-one cases.

We found the average age of our cases to be 44 years old. This may be compared with the average age of 38.7 years in the series of cases reported by Pund and Auerbach. The mean age of our patients, however, was found to be 39 years old and varied from a low of 27 years to a high of 65 years.

As regards symptomatology, thirteen of the cases were discovered during routine examinations or after presenting such signs of benign uterine disease as procidentia, pelvic pain, retroversion, fibroid disease of the uterus, etc. It should be noted at this point that all our patients according to the records available had either symptoms or signs of some pelvic disturbance. The thirteen cases mentioned above include three patients who were found to have lesions of their cervixes during the early part of their pregnancy and one case which was discovered during the postpartum checkup. Thirteen other cases presented as their major complaints excessive or irregular vaginal bleeding. These cases include one patient who complained of slight bleeding after intercourse and others who had daily vaginal bleeding for as long as two years. One patient who complained of continuous vaginal bleeding was discov-

ered to have an ectopic pregnancy. In the course of her examination she was also found to have carcinoma in situ. The five remaining cases presented as their major symptom leucorrhea which varied in type from a watery discharge of eight months' duration to a thick yellow discharge of two years' duration. It may thus be seen that of all our cases 58 per cent had complaints which might be ascribed directly to the cervix.

Upon vaginal examination, twenty-five of our cases were found to have a lesion or abnormality of the cervix. Eighteen of these cases were described as having an erosion or ulceration of the cervix. Two cases were found to have Nabothian cysts, while in two other patients small nodules were seen on the lip of the cervix. The three remaining cervixes were described as being thickened, having a "deformity" of the posterior lip, and simply being inflamed.

Vaginal smears were used in the diagnosis seventeen times. The smears were always Class III or Class IV except in one case where two smears were done, the first one being negative. Twenty-six of the cases had biopsy specimens taken, twenty-four being positive for carcinoma in situ and two being negative. One of the negative cases had repeat biopsy specimens taken eight months later and was then found to be positive. The other negative case had a clinical picture of spotting after intercourse, and a panhysterectomy was done because of the suspicious nature of her history. The remaining five cases were discovered incidentally, following hysterectomy for other purposes.

Twenty-four of our cases were treated by total hysterectomy, ten included tubes and ovaries. Four cases were treated by radium and radiation therapy, and one case was treated by simple cautery. Incidentally, the case which was treated by cautery has had a follow-up of eight years with no recurrence reported. In the last two cases cervical stumps were removed. These two cases might very nicely demonstrate why a supracervical hysterectomy should almost never be done. All thirty-one cases have had a follow-up by our Tumor Clinic of from one to eight years, and there has been no reported case of recurrence, regardless of the method of treatment employed.

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## INFECTED RENAL CYST

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## SUMMARY

An unusual complication of simple renal cyst has been presented with a review of the literature. The roentgen findings are consistent with a mass lesion of the kidney. The diagnosis is usually made at the time of surgery or after pathological examination. Treatment is governed by the same principles which apply to simple cyst.

IN THE absence of aspiration, infection is an unusual complication of simple renal cyst. Thirteen cases of suppuration in kidney cysts were found in the literature.

H. B. Sweetser (1929) reported a large, infected, solitary cyst of the kidney and referred to the case of Patel and Mallet-Guy. In separate articles, J. Cibert (1937) described two cases of infected cyst and mentioned a paper by Botta-Micca. Fang (1938) discovered infection of a renal cyst in an adult female. The only known instance of a spontaneously infected renal cyst in a child was reported by Chalkley and Sutton (1943). Ficara (1950) performed a nephrectomy for this disease. Abeshouse (1950) in his article on serous cysts of the kidney included the cases of Boeminghaus, Cassioli and Dzienbowski as examples of infected cyst. An infected cyst of the right kidney in a 27 year old negress was successfully resected by Nelson and Hopper (1952).

## CASE REPORT

T. M., a 66 year old white housewife and former acrobatic dancer, was admitted to the Hartford Hospital on September 3, 1952 with a three year history of back pain, suprapubic discomfort and vesical irritability. There was a 25 pound weight loss over this period. With the exception of a hysterectomy, her past history was negative.

The pertinent physical findings were: hypertrophy of the

trapezius muscles; a well healed lower abdominal incision; some left flank and suprapubic tenderness, and an absent uterus.

The specific gravity of the urine was 1.006 with 2 plus albumin and many white blood cells. The hematocrit was 38 per cent and the white blood count 5,100 per cu.mm. The non protein nitrogen was 38 mg. per cent.

An outpatient barium enema demonstrated diverticulosis. On excretory urography, there was prompt bilateral function with a normal right kidney and ureter. The left kidney contained an upper pole mass with calyceal distortion. A chest plate was negative.

On September 4, cystoscopy revealed a low grade cystitis. The colon bacillus was isolated from the bladder and right kidney urine. Pyelograms showed a dense six cm. mass occupying the superior pole of the left kidney with flattening of the upper calyx and narrowing of the infundibulum of the middle calyx with proximal dilatation (Figure 1).



FIGURE 1

Bilateral retrograde pyelogram shows a left upper pole mass with flattening of the superior calyx and dilatation of the middle calyx



The left kidney was explored on the following day. The upper pole was partially replaced by a soft raised mass which held 200 cc. of odorless pus. A nephrectomy was done. A one plus growth of hemolytic staphylococcus was cultured from the cyst.

On pathological examination, the left kidney was pyelonephritic with a collapsed, noncommunicating, upper pole cyst. The wall was thickened and the lining composed of low cuboidal epithelium (Figure 2).



FIGURE 2

High power photomicrograph illustrates the low cuboidal epithelium of the cyst wall which is thickened. Round cell infiltration indicates a chronic inflammatory process

The patient received dihydrostreptomycin 0.5 Gm. every 6 hours. She was allowed up on the first postoperative day. The wound healed nicely and she was discharged on the 8th day. Her condition has remained completely satisfactory.

#### DISCUSSION

Infection, although rather common in polycystic disease, is distinctly unusual in solitary cyst. Contamination by bacteria, in the absence of aspiration, probably occurs via the blood stream or more remotely through the lymphatics. Nelson and Hopper suggest that infection may spread across the tissue barrier of the cyst wall from the kidney.

The clinical picture is that of acute or chronic renal infection and the urinary findings will depend upon the degree of associated parenchymal disease. It has been estimated by Davidson that 35 per cent of simple renal cysts have additional pathology in the kidney. The cyst may be large or small. The pyelographic changes are those of a space occupying lesion and immediately suggest tumor or cyst of the kidney. Solitary abscess, carbuncle, hydatid disease, and infected calyceal diverticulum with obliteration of the infundibulum should be considered in the differential diagnosis. At operation a soft, fluctuant area in an adherent kidney is usually found. The treatment is either resection of the involved portion or nephrectomy. Simple aspiration has been employed by some.

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## SWALLOWED FOREIGN BODIES

### Two Case Histories

CHARLES L. LARKIN, JR., *Waterbury*

#### CASE ONE

The patient, W. E., a twenty-four year old male, swallowed a total of eighty-nine foreign bodies. These objects were swallowed on four separate occasions, which are briefly reviewed. Selected x-rays are included.

On his first admission he swallowed a small medal, two washers, two bolts one inch long, four star washers, two flat washers, one metal button, four sheet metal screws  $\frac{5}{8}$ " long and twenty razor blades broken lengthwise to make forty pieces. The razor blade halves, in groups of ten or twenty, were said to have been swallowed wrapped in wax paper. Some were still in the paper when later recovered in the stool.

X-ray No. 1, taken on admission, shows some of the above mentioned material lying in the stomach. W. E. obtained and swallowed the other foreign bodies soon after admission. X-ray No. 2, taken on the fourth hospital day, reveals that most of the materials had already been evacuated. During this four day period the patient never vomited, became distended, passed blood by rectum, nor developed abdominal spasm. There was, however, some right lower quadrant tenderness.

All metal objects had been passed by the seventh day.

Four days after discharge from the hospital W. E. was readmitted. This time the materials swallowed were larger, and consisted of twelve wood screws  $1\frac{3}{4}$ " long, and two safety pins with their heads broken off and open about one-half an inch. Again there was tenderness in the right lower quadrant, later tenderness in the left upper quadrant without spasm, without vomiting and without the passage of blood.

Plate No. 3 shows these foreign bodies cradled in the stomach with the dull ends pointing towards the pylorus. X-ray No. 4, taken four days later, reveals most of the wood screws still in the small bowel and the open safety pins in the cecal region.

In eleven days the remainder of the material had been eliminated without mishap.

Up to this time the patient had swallowed and passed with ease a total of seventy foreign bodies.

Five months after the previous admissions this same man was readmitted. This time, in all he swallowed three wood screws, eight razor blade halves, one faucet handle  $2\frac{1}{4}$ " long and  $\frac{1}{2}$ " in diameter, one small crucifix, one ball chain 18" long, one razor handle 3" long, one spoon handle  $3\frac{3}{4}$ " long and two  $\frac{5}{16}$ " bolts 4" long.

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The Author. *Surgical Clinical Assistant, St. Mary's Hospital and Waterbury Hospital*

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The patient was treated conservatively as before and remained asymptomatic. An x-ray (No. 5) on the seventh hospital day revealed that, though the smaller objects (faucet handle, razor handle, ball chain, and razor blade halves) were progressing satisfactorily, the longer, heavier materials were not.



FIGURE 1

Since these five large metal pieces (two spoon handles, one case knife blade, and two bolts) all measuring about 4" in length, did not move out of the stomach in eight days, it seemed best to remove these by gastrotomy.

At operation there was no evidence of damage to the stomach wall inside or out. The remaining foreign bodies in other parts of the intestinal tract were not disturbed. On the second postoperative day the patient vomited a small screw, otherwise his postoperative course was uneventful. The remaining objects, not removed at gastrotomy, were evacuated spontaneously.

One month after gastrotomy W. E. swallowed a tablespoon





FIGURE 2

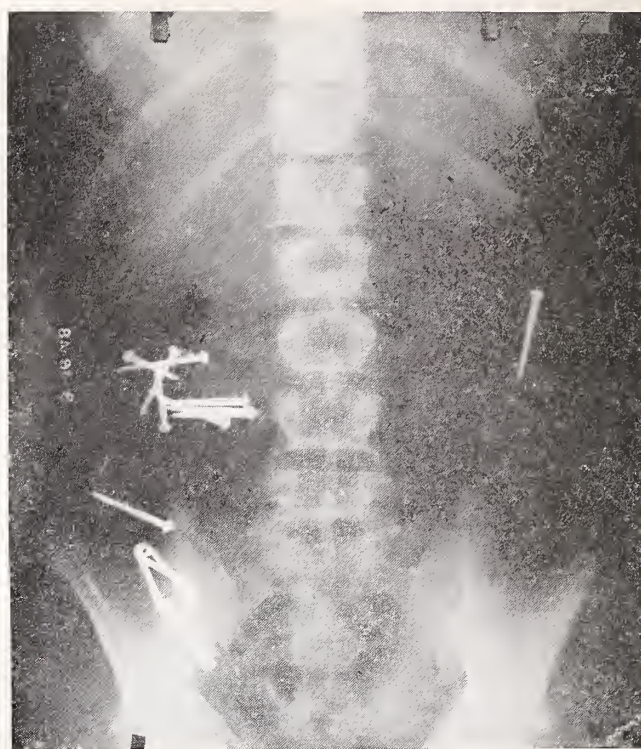


FIGURE 4

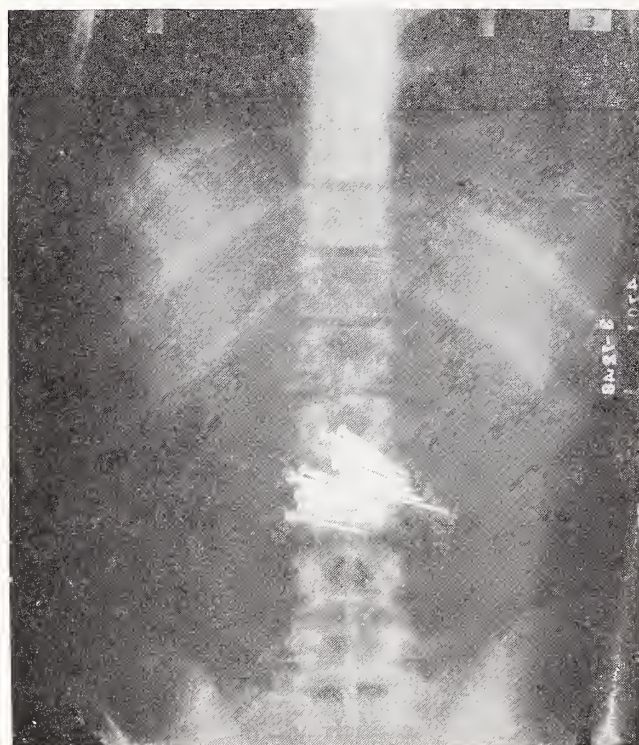


FIGURE 3

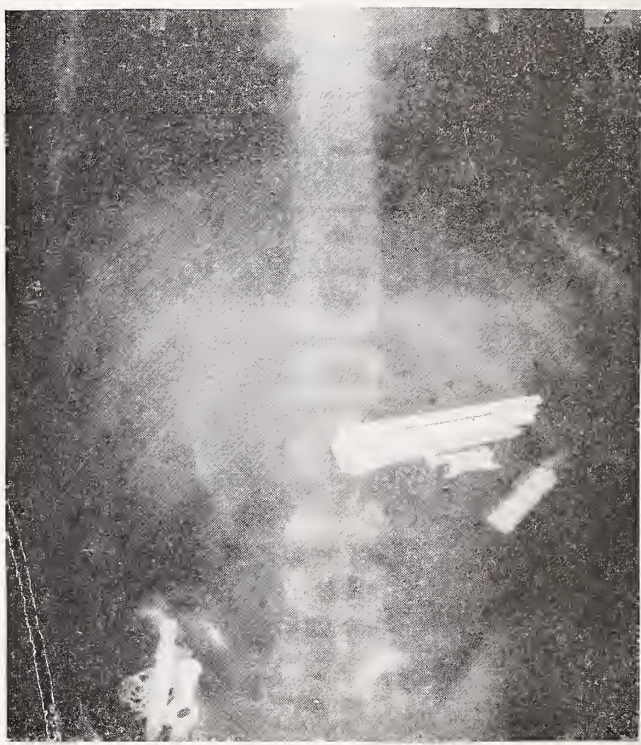


FIGURE 5

handle measuring 4", shown in x-ray No. 6, which was passed without difficulty and without treatment.

In summary: Of the eighty-nine foreign bodies swallowed, eighty-three went the usual route. It was possible for this patient to eliminate without opera-

tive intervention foreign bodies of various shapes as sharp as a razor blade and as long as a table spoon handle (4"), but on the other hand it was not possible for this patient's stomach to move on at the same time five 4" metallic objects. Perhaps their





FIGURE 6

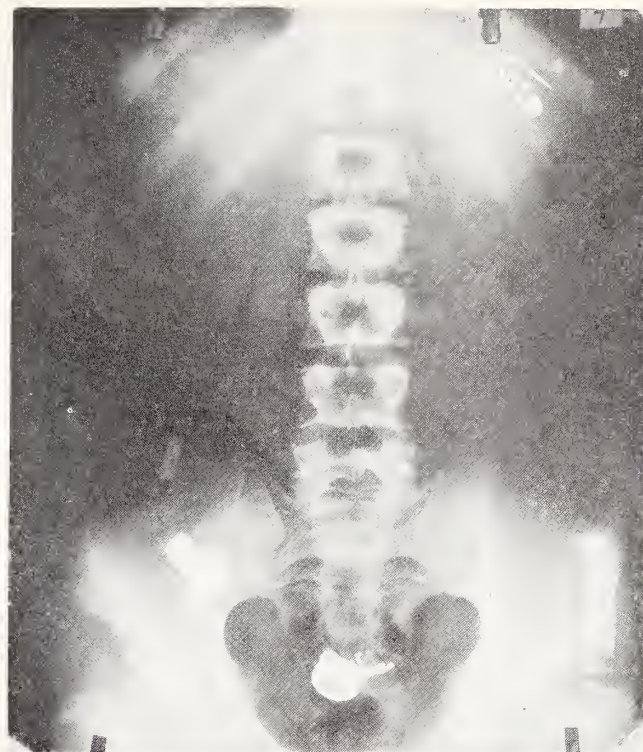


FIGURE 7

aggregate weight prevented this. The fact that the tablespoon handle of about equal length passed without incident when swallowed alone supports this impression.

#### CASE TWO

V. E., 26 year old male, was admitted twelve hours after he had swallowed eight injector type razor blades, one open safety pin, one drapery hanger, a key chain and three coins—14 objects in all. He stated he had done this on a dare. Three years previously he had swallowed a single razor blade under similar circumstances. At that time the razor blade was removed surgically through a transverse abdominal incision.

Abdominal examination on this admission revealed no spasm or distention, though there was some slight tenderness in the left upper quadrant. A chest plate revealed an open safety pin lying in the distal esophagus, about three cm. above the cardia, with its blunt end pointing downward. A flat plate of the abdomen revealed the other materials scattered throughout the small bowel.

The patient was permitted to eat a regular diet. An x-ray (Figure 7) taken on the second hospital day showed that the safety pin had moved into the stomach and that the other material had progressed toward or entered the cecum. On this day the patient passed the three coins per rectum.

An x-ray on the fourth hospital day revealed that the safety pin was already in the ascending colon and the drapery hook was near the cecal region. On the fifth hospital day the open safety pin was passed.



FIGURE 8

The patient vomited small amounts of blood from admission until the fifth day, had melena from the second until the sixth hospital day, and had sharp pain beneath the xiphoid process on deep inspiration on the second day.

During this period of bleeding, the red blood count



dropped nearly one million cells per cubic mm., but a blood transfusion was never considered necessary. The abdomen, however, remained soft, the temperature normal, and chest plates failed to show evidence of mediastinitis.

On the eight day an x-ray (Figure 8) showed the drapery hook still at the ileocecal valve area. Because the drapery hook had not moved appreciably in six days, and because frequent bloody stools and sharp pains in the right lower quadrant continued, the patient was operated upon for removal of this object.

At operation under spinal anesthesia, the drapery hook was not found in the terminal ileum as expected, but free in the cecum. There was no evidence of peritonitis, free fluid or injury to the bowel wall. The hook was removed through a small hole in the anterior wall of the cecum and manipulated in such a fashion so as to remove it without enlarging the hole. A purse-string suture closed this defect.

By the third postoperative day the remaining metallic material had been passed by rectum.

In summary: Fourteen foreign bodies were passed by this patient without difficulty, including eight

unwrapped razor blades. In retrospect, the drapery hook probably would have been passed by the patient. It is possible that spinal anesthesia had relaxed the ileocecal valve allowing the drapery hook to enter the cecum while the operation was in progress. It is probable that the safety pin, caught in the lower esophagus for twenty-four hours, accounted for the early hematemesis and the drapery hook at the ileocecal valve accounted for most of the later melena.

These two cases are presented to encourage watchful waiting as the procedure of choice in handling patients who have swallowed foreign bodies.

Later, if an object has failed to advance over a period of days, surgical removal may be indicated.

Perforation of bowel, the clear indication for surgical intervention, did not occur in either patient though 103 foreign bodies were swallowed jointly.

## REHABILITATION TODAY

MARY E. SWITZER, *Washington, D. C.*

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The Author. *Director, Office of Vocational Rehabilitation, U. S. Dept. of Health, Education, and Welfare*

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**W**ORKING quietly and steadily—with the help of such groups as this and, indeed, with the medical profession throughout the Nation—our national system of vocational rehabilitation for disabled civilians has made dramatic, if unacclaimed, progress in many of the more difficult areas of disability.

Let me give you some examples of what I mean. A few years ago it seemed hopeless for us even to try to work a severely afflicted epileptic into a steady job situation. The superstition prevailed on an unbroken front that insanity was somehow inseparable from epilepsy. Even the terminology suggested—and still suggests—that the victim was possessed of the devil. “Seizures,” we call the attacks—seizures by the evil spirit. Yet, we have made progress along that front—remarkable progress.

In 1944, when our new law was put in effect, we rehabilitated only 116 epileptics into successful employment over the entire Nation. During the fiscal year that ended last June, the number was above 1,250. That is better than ten-fold increase and more important than the volume is the fact that we are removing the prejudice, removing the superstition that so long has doomed all too many epileptics to the role of outcasts.

In the orthopedic field our noticeable advances may be best illustrated by the fact that we had no separate listing for paraplegics until 1949, so few were considered capable of restoration to self-supporting status. In 1949 our record shows 21 paraplegics rehabilitated; last year the number was close to 400. The wheel chair is no longer an uncommon sight in the factory or the store. People generally have become aware of the fact that paralysis from

the waist down is not as bad as paralysis from the ears up.

Similar progress has been made against the prejudice that for so long has precluded the mentally ill from return to normal life and work. Ten years ago fewer than 1,000 men and women who had recovered from their mental disabilities were rehabilitated into employment. Last year the number was three times as great.

Progress again has been made in one of the most heart rending of all situations—in the rehabilitation of the cerebral palsied. These people face perhaps the most difficult of all roads to success, but more and more we are proving that a jerking gait and a grimacing mien can be accompanied by a brilliant mind and superlative competence. There again is progress against superstition and prejudice. The progress is slow but it is steady; where we rehabilitated 238 persons with cerebral palsy in 1944, the number last year was 800.

Still one of the most distressing disabilities—and most frustrating to a rehabilitation worker—is multiple sclerosis. Here the terrible obstacle is that we have not yet found a cure or a proved method of arresting the disease. In 1944 we rehabilitated not one person with multiple sclerosis; last year the total was 147. And the search continues for the arresting technique with some evidences that progress in that direction is being made by those men of medicine who refuse to give up hope.

These advances add immeasurably to the happiness and chances for success of those who suffer such grave afflictions as I have mentioned. But, aside from the humanitarian, social and technical values of this work, there are most important economic aspects.

Vocational rehabilitation for our disabled civilians offers one of our brightest hopes of reducing the tremendous burden of dependency which the American taxpayer is carrying.



The record of the past fiscal year—just now unfolding in statistical tables—is convincing evidence that we can wipe out a considerable portion of relief payments that have been made necessary by disability.

Somewhere between 11,000 and 12,000 disabled persons were returned to employment from the relief rolls last year. That is almost one in every five rehabilitated through the State-Federal program of vocational rehabilitation—some 61,000 all told.

These 11,000-12,000 people and their dependents were receiving relief payments of something more than \$8 million a year. It cost about \$7 million to rehabilitate them. Instead of living on the miserable pittance of relief—expensive as it is to the taxpayer—they are earning at the rate of about \$22 million a year. In other words, because of vocational rehabilitation these relief recipients and their families are about three times as well off financially. In addition they have regained self respect; and they have prospects of many years of productive effort and normal living ahead of them—on their own. On the other side of the book, a public expenditure of \$8 million a year for their support is eliminated. That is a matter of striking economic and social importance when we consider that the annual saving from this source alone is roughly one-fourth the total cost of the public program of vocational rehabilitation.

That, of course, does not take into account the fact that the 61,000 disabled men and women who were returned last year to employment through vocational rehabilitation are paying Federal income taxes at the rate of \$10 million a year. In about two years they will return to the Federal government in income tax payments every Federal dollar that was spent on their rehabilitation. Then they will continue to pay taxes for years to come.

These 61,000 rehabilitated men and women add 100 million man hours a year to our productive effort, increasing the Nation's strength. And they add almost \$100 million to their yearly earning power, strengthening their economy along with that of the Nation. They take their part in community life and become contributing, participating, and self-sustaining citizens rather than continuing as a burden to the community. They pay their State, county and local taxes and they make America proud of them.

It is highly commendable that our State-Federal partnership in vocational rehabilitation is devoting more attention to removing disabled public assistance recipients from the relief rolls. But much more needs to be done in that area.

A quick look at the situation will open the eyes of most of us. Last year the costs of public assistance which were directly attributable to disability amounted to more than \$400 million. Some one million Americans were living on relief payments because of disabilities—and living so meagerly that their hopes of improvement seemed dim. About 600,000 of these were adults—disabled adults—and about 400,000 were children who were dependent—not upon their disabled parents—but upon the public.

In Connecticut alone the annual payments in public assistance because of disability are running about \$1,980,000. Aid to dependent children with disabled parents accounts for \$1,600,000 of that. Aid to the blind accounts for another \$348,000 and the disabled on general assistance rolls account for about \$31,000.

The sad thing about this picture is that so much of it is unnecessary. Many disabled men and women who are public charges can be restored to productive and self-supporting lives.

29th CONNECTICUT CLINICAL CONGRESS  
of the  
CONNECTICUT STATE MEDICAL SOCIETY  
and the  
YALE UNIVERSITY SCHOOL OF MEDICINE

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Grace-New Haven Community Hospital and the Yale School of  
Medicine, New Haven

September 15, 16, 1954

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The 1954 Clinical Congress will be concentrated in two days and all of the meetings will be held at the New Haven Hospital and the Yale School of Medicine.

Three sessions will be held simultaneously in three different meeting places giving a broad selection of topics. Material in the fields of vascular diseases; psychiatry; drug and alcohol addiction; pediatrics; general medicine; general, special and traumatic surgery; and other related subjects will be presented.

Registration for members of the Society will be \$3 and non-members \$4. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be served on both days by the New Haven Hospital.

MAKE A NOTE OF THESE DATES ON YOUR CALENDAR



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### The Federal Grants-in-Aid Program

It is evident by certain events which have transpired recently that the present administration in Washington is attempting to meet the criticisms levelled at Federal participation in State and local activities. Frank discussions of the problem have been carried on before public audiences by Oveta Culp Hobby, the head of the new Department of Health, Education and Welfare. Mrs. Hobby has met the issue squarely and her explanations and solutions have been clear and sound.

In addition to the information released by Mrs. Hobby the U. S. Commission on Intergovernmental Relations is making an honest effort to collect a fair sampling of public opinion on the entire grants-in-aid program by sending out a questionnaire to public groups. Our own State Medical Society has received such a questionnaire and has expressed itself through its Committee on Public Health and through its Council.

There are many rugged individualists who would throw out the entire grants-in-aid program and return to the beginning of the century when the word tax meant little more than an annual payment to the town treasurer for real estate owned and occupied. But the past 40 years have seen a considerable change in the program of taxation in the United States and have necessitated adjustments in our thinking as individuals. There has come about a shift in responsibility from local to State to National government attendant on a growth in government itself. Forty years ago the local governments collected and spent two-thirds of all taxes in this

country; State and National governments shared the remainder. Now the Federal government collects about three-fourths of all taxes while State and local share the remainder. The local governments now receive less than one-eighth instead of two-thirds of the U. S. tax dollar as formerly. The dividing lines between local, State and National governments have become blurred as government has steadily moved away from the people. State and Federal governments now carry on many activities formerly accomplished by local governments.

It must be apparent to all who have studied this problem that grants-in-aid are here to stay. The real difficulty lies in just how much control should be exercised by the Federal government. It has been sharply criticized for interference but this interference in the last analysis is the result of the establishment of certain standards which have been required of State and local governments in return for the money supplied to carry out many programs.

Connecticut, because of its high income level, is particularly well situated and has less need for Federal grants than the 29 States where the per capita income is below the national level. The business of government has become so huge and so complex that the Federal government and the States must share the responsibility and act as partners in serving the people. This applies in Connecticut as well as in Mississippi. The responsibility of carrying out the programs in our State should and does rest with State and local governments. But because many States have a low tax-paying ability the Federal government believes, and probably quite rightly so, that it has a responsibility, even for some of these

domestic functions, in situations where individual States are unable to provide them. Hence, the grants-in-aid program is necessarily larger for some States than others.

Our Society's Committee on Public Health has expressed approval of the Federal Grants-in-Aid program. It has said, however, that it believes Federal funds should not be used as an indefinite substitute for State and local governmental appropriations for health programs which are accepted by such State and local groups as being worthwhile. The Committee feels that insufficient Federal funds ultimately reach local committees as such because of the cost of State administration. In some instances the Committee has found that the grants-in-aid furnish funds to activities for which adequate State funds already exist and which cannot be diverted to other activities in need of financial support.

Whatever opinion in this matter one may cherish as an individual, the grants-in-aid program has attained sufficient recognition by Congress to insure its permanency. It should function on a partnership basis. Connecticut, because of its high per capita income, has less need than many other States where Federal funds have been a boon to the citizenry in raising standards and providing valuable health and welfare services. Because of the differences in State requirements the Federal government must continue to exercise some control in the allocation of tax funds. It seems to be the desire of the present administration to keep this control at a minimum.

### Medical Catastrophic Insurance

Major medical expense insurance is demanding increasing attention of employers and unions. It is regarded as the most important development in group coverage of the last 20 years and one of the most important factors of the future in employer-employee relationships. Since its inception five years ago the number of employees and their dependents in U. S. and Canada covered by the new form has grown to more than one million. More than 25 insurance companies have entered this rapidly expanding field.

Major medical expense insurance, sometimes called medical catastrophic coverage, is an experimental form of protection intended to give financial aid against large medical bills. It supplements the usual forms of hospital, surgical and medical expense insurance, which are limited as to amounts paid.

Services of specialists other than surgeons are not generally provided for in surgical expense policies, while the benefits in medical expense policies are very small in comparison to specialists' bills. To meet these and similar problems reflected in higher hospital and surgical bills, policies now being issued generally contain higher benefits and longer covered periods than those of a few years ago. However, this does nothing about the many expensive types of treatment which are not included in limited forms. The new major medical expense insurance was designed to include them.

Major medical expense insurance contains two factors not usually found in the conventional basic coverages. These are the "deductible" and "co-insurance factor." The deductible follows the same principles as in automobile collision insurance. By cutting out the expense of paying small claims, the deductible principle permits much lower premium rates than would otherwise be necessary.

This medical catastrophic insurance contract is now available to members of the Connecticut State Medical Society.

### Accidental Deaths in Connecticut

Only one State, New Jersey, has a lower accidental death rate than Connecticut. In the period 1949-1950, according to Metropolitan Life Insurance Company analysis, New Jersey had the lowest rate, 42.6 per one hundred thousand, and Connecticut was a close second with 44.8 per hundred thousand.

The lowest death rates from accidents are found in the Northeast. In the Middle Atlantic and New England Areas the accidental death rate was about  $\frac{1}{6}$  below the national average in the period covered. The highest is in the Mountain Area and there it is 81.5 per one hundred thousand or  $\frac{1}{3}$  above the national average of 60.7. Nevada and Wyoming had the poorest showing with rates exceeding one hundred per one hundred thousand.

Motor vehicle mishaps comprise a major item in the total picture. Fatal injuries in such mishaps exceed the toll from every other type of accident in all other areas except the Northwest and even there they rank second only to falls, which are the most important cause of accidental death in the Northeastern States. The highest death rates from falls are found in Massachusetts, Rhode Island, Iowa, and Missouri, probably because the population in these areas includes a relatively large proportion of



older people who contribute the bulk of the deaths from falls.

The accidental death experience for Connecticut shows that for every one hundred thousand of population there are 44.8 deaths. Of these 12.9 are caused by motor vehicles; 15.4, by falls; 3.2, by burns and conflagrations; 3.0, drowning; 0.3, firearms; 0.4, machinery; 2.1, absorption of poisonous gas; 1.1, poisoning by solids and liquids and 0.6, by water transport.

### Iatrogenic Diseases

*"O wad some Power the giftie gie us  
To see oursel as ithers see us!  
It wad frae monie a blunder free us."*

*Robert Burns*

According to a Swedish letter in the *Journal of the American Medical Association*\* discussion of the problems of iatrogenic disease, that is, illnesses caused by physicians themselves, has been very popular in the Scandinavian medical press of late. This is as it should be, for the last thing that any conscientious doctor wishes is to increase rather than cure his patients' ailments.

There are two important considerations which a practitioner must always bear in mind in his discussions with patients regarding their illnesses: (1) that roughly a third of them are probably suffering from psychoneuroses, and (2) that a great many of them are familiar with the exact meaning of medical terms.

The fact that a considerable proportion of patients are mentally rather than physically sick indicates that the doctor must take unusual pains to avoid the use of language, to them ambiguous, because they may draw false conclusions from it which will aggravate rather than ameliorate their mental condition. Dr. Forsmann, a Scandinavian psychiatrist, points out that physicians of the anxious, overconscientious type who are not sure of themselves and are inclined to hedge are the ones most likely to do damage to psychoneurotic patients.† As Forstmann remarks such physicians dislike taking responsibility for the positive reassurance of their patients. They undermine the patient's confidence because they know that medical diagnosis is not 100 per cent perfect and are foolish enough to drop hints during their conferences with patients which indicate to

the psychoneurotics uncertainty of mind when what is needed is clearcut positive opinions.

Forstmann also notes that psychoneurotic patients who are allowed to get glimpses of reports on x-rays, blood pressure readings, or electrocardiograms may draw entirely false conclusions as to their significance. This applies particularly to hypochondriacs and patients with mental development below the average. As Walter Alvarez points out in his newspaper column, much damage to patients may also be done by overworked doctors who fail to discuss with their neurotic patients the problems underlying their ailments.

Unfamiliarity with medical terms is likely to be due to the fact that the education of many patients has not gone beyond the eighth or ninth grade or to the complexity, even to highly intelligent patients, of some medical terms. This results in the misinterpretation of words as happened in the case of a patient who caught a glimpse of the word "cancerophobia" in a report from a specialist to her family doctor. Not knowing the import of the suffix "phobia," she drew the false conclusion that she had cancer.

It follows from these considerations that physicians who talk to psychoneurotic patients must use plain, simple language, must avoid technical medical terms, and must make sure that the keynote of their messages is reassurance. If patients have been referred by the family doctor to specialists for laboratory tests or for opinions on particular aspects of their sicknesses it is best to have the family doctor explain the results, and patients should not be given opportunities to scan the records transmitted to him lest they glimpse words or phases which they may misinterpret.

G. B.

\*1954, 154:1113

†Loc. cit.

### Fred Rankin, Former AMA President

Fred Wharton Rankin, president of the American Medical Association in 1942 and of the American Surgical Association in 1949, has passed on to his reward. Fred Rankin will be remembered by many physicians in this country and among our allies for his leadership during the years of World War II. A major in World War I, Fred Rankin's knowledge

of medical military affairs won for him the distinction of chief consulting surgeon of the army with the rank of brigadier general in World War II. For this latter task performed with unusual ability he received the Distinguished Service Medal from our government and the Cross of Chevalier of the Legion of Honor from the French government.

Fred Rankin made up for his short stature by his fearless courage. It was he when retiring as president of the AMA who warned the House of Delegates that physicians are too reluctant, even hostile, toward accepting the responsibilities which are ours in the current socio-economic developments of our nation.

Fred Rankin will be missed. He was a great surgeon, a recognized leader, an accomplished soldier. Those who knew him valued his loyal friendship.

### Dean Sperry

The passing of Willard L. Sperry, dean of Harvard University Divinity School, removes from New England one of the medical profession's staunch friends. It was Dean Sperry who encouraged and assisted in the establishment of a Protestant chaplaincy at the Massachusetts General Hospital. It was from this same hospital that problems belonging in the realm of moral philosophy rather than medicine, but which nevertheless frequently confronted the thoughtful physician were referred to him for consideration.

In reply to an invitation to discuss these problems Dean Sperry met with many of the senior members and most of the junior members of the medical staff at the M.G.H. on a certain afternoon a few years ago in the historic ether dome of the old Bulfinch Building. The text of that lecture was subsequently printed as the leading article in an issue of the *New England Journal of Medicine*. Then in 1950 Dean Sperry extended his thoughts and published them in a book entitled "The Ethical Basis of Medical Practice." Physicians will find this volume a very valuable guide in dealing with problems confronting the doctor of medicine and his patient. Coming from a great man who as an undergraduate had looked forward to the general field of medicine, and to surgery in particular, as his probable profession, his views on moral and ethical issues will be contemplated with respect as well as interest.

Medicine has lost a wise counselor.

### The Need For the Deductible Clause in Voluntary Health Insurance

Medical Expense Insurance is now accepted by millions of people as a readily available commodity. It has advanced beyond the early stage of experiment, but for obvious reasons it should not be regarded in its present form as a finished product.

Progress and accumulated experience in this relatively new field have both created and demonstrated certain limitations of an actuarial nature, although some of them because of their very nature were not readily discernible at the outset.

All who are fair-minded, but few of those who are impatient, will endorse this basic fact, common to all business undertakings, that somewhere, somehow, and at some time goods and services must be paid for at current costs. This holds true moreover in the insurance field irrespective of how the immediate rate and benefits to the consumer may be influenced by the total assets in the insurance pool, the time spread governing payments, the risk involved, and other items of like nature. It is immature to assume, as many people do assume, that by some manipulative dexterity or economic alchemy basic costs can be transmuted into thin mist.

Deducing from this then that all human and social benefits are not created equal, that in the long run and in the overall we collectively get only what we pay for, it behooves us to exercise restraint in our current demands to get more for less, and to be satisfied with benefits that bear some reasonable relationship to our individual efforts. Any attempt to solve the costs of medical care without consideration of this factor is fraught with difficulty.

The original purpose of medical expense insurance was to offset the staggering cost of catastrophic illness or extraordinary medical services. It would be unfortunate, and it might spell failure for the plan, if this original purpose were not reiterated. Recently, Mrs. Oveta Culp Hobby, Secretary, Health, Education and Welfare Department, repeated what is and has been for a long time the opening gambit in any discussion of costs of medical care—and properly so, that the middle income group, the vast majority of the population, is the one which is hardest hit when extraordinary illness strikes. Even so, there was not nor is there usually any mention of the fact that this group still has in these days of television screens, garbage disposal units, and electric



washing machines some measure of individual financial responsibility for its ordinary medical care.

Total medical expense coverage at the present time is an unlimited risk which no insurance company can properly undertake. It strained the resources of a couple of countries, let alone companies, that tried it, and it is significant that one of the countries, England, in desperation presently shifted some of the financial burden for small items back onto the individual consumers because, in the well known phrase, it was being "five and ten dollared to death."

There is great significance in this. It is not for nothing that many of our leading commercial companies with their vast experience behind them are now offering attractive \$100, \$300, and \$500 deductible policies for medical expense coverage with the premiums restrained and the ultimate benefits greatly extended because the overwhelming burden of payments for minor medical expenses is eliminated. It is not for nothing that people are taking them up with commendable wisdom and foresight.

Abraham Lincoln contended that if you give the people all the facts, they will soon come up with the answers. Evidently somebody has been talking to some of the people, or maybe with their knowledge of insurance and business and sense of proportion they have already talked quietly to themselves. The people are already conditioned; they know what would happen to rates and the upper limits of payments if every driver made claim for the six dollar dent in the fender. They know how the deductible feature makes their collective insurance position secure.

In the final analysis the choice will be up to the people. But first, they must establish this fact: that medical expense insurance is strictly insurance and not a glorified handout. They must subscribe to the principle that if they insist on being paid for the peanuts, they can't expect to be paid much for the lemons.

In the nonprofit medical expense insurance companies we have witnessed the steady rise in rates brought about undoubtedly in large part, and aside from certain correctible abuses, by the lack of the deductible feature. The upper limits of payments originally planned for the difficult situations are being held down because these companies too have to face the potential danger of being "five and ten dollared to death."

There is evidence that the people are awakening. You can fool some of the people some of the time, and for a limited time some of the people make fools of themselves, but people rarely waste much time in finding out where their bread is truly buttered. The deductible feature will soon have broad appeal.

It is respectfully suggested that the time has come for the nonprofit medical expense insurance companies to issue policies with the deductible features built in. Individuals in the middle income group, once given all the insurance facts, should be willing to pay for ordinary medical expenses so that on sound actuarial grounds extraordinary medical expenses will never constitute hardship.

*From the Westchester Medical Bulletin, (December, 1953)*

## Record Number of Physicians Licensed to Practice Medicine

An all-time record number of physicians—218,522—were licensed to practice medicine in the United States at the close of 1953, it was disclosed in the 52nd annual report on medical licensure of the American Medical Association's Council on Medical Education and Hospitals.

Of this total, 156,333 were engaged in private practice, 6,677 were engaged in full-time research and teaching and were physicians employed by insurance companies, industries, and health departments, 29,161 were interns and residents in hospitals and those engaged in hospital administration, 9,311 were retired or not in practice, and 17,040 were in government service.

According to the report, during 1953 there were 14,434 licenses to practice medicine issued by the 48 States, the District of Columbia, Alaska, Canal Zone, Guam, Hawaii and Puerto Rico—an increase of 1,206 over the number issued during 1952 and the third largest number issued in the history of this country. Of this total, 6,565 were granted after written examination and 7,869 by reciprocity or endorsement of State licenses or the certificate of the National Board of Examiners. The majority of those issued by reciprocity or endorsement were to already licensed physicians who moved their practice from one State to another.

The data presented in the report showed that last year 7,276 physicians received their first license to practice medicine. In the same period there were approximately 3,421 deaths of physicians reported,

so that there was a net gain of 3,855 in the physician population in the United States and its territories and outlying possessions. During 1952, there was a net gain of 2,987.

The greatest number of licenses issued in 1953 was granted by California—1,977. New York was second with 1,348 and more than 500 physicians were registered in Illinois, Ohio, Pennsylvania and Texas. Less than 50 licenses were issued by Nevada, Delaware, Idaho, Montana, New Hampshire, North Dakota, South Dakota, Vermont, and Wyoming.

From 1935 through 1953, a total of 207,744 licenses to practice medicine was issued in the United States. During the same period there were 119,510 additions to the medical profession—an increase reflecting accelerated programs in medical schools, expanded facilities, and the licensure of foreign trained physicians.

The excellent rating of the nation's and Canada's approved medical schools was pointed up by the number of applicants who successfully passed examinations. Thirteen per cent of the total number of applicants who took written examinations for licensure failed, the report stated. Only 3.8 per cent of the graduates of approved medical schools in the United States and 4.1 per cent of those of approved Canadian medical schools failed. In contrast, 50 per cent of those graduated from now extinct medical schools in the United States failed, as did 45.5 per cent of the graduates of foreign medical faculties, 70.2 per cent of graduates of unapproved U. S. medical schools no longer in existence, and 13.4 per cent of graduates of schools of osteopathy.

The current report on medical licensure revealed that in many states the licensure of foreign trained physicians has been given serious consideration by the authorities and that methods are being developed to provide for the licensure of such physicians which will not lower the standards of medical practice in the United States.

However, the report stated, the Council on Medical Education and Hospitals of the AMA, the Association of American Medical Colleges, the Federation of State Medical Boards, and other interested agencies now are engaged in discussions looking toward a re-evaluation of the problem created by the influx of foreign trained physicians migrating to the United States to pursue their profession.

The number of graduates of foreign faculties of medicine examined began increasing in 1936, and by

1940 there were over three times as many tested as in 1936, according to the report. Beginning in 1944 the numbers examined began to decrease until 1951, when there was a noticeable increase, an increase again recorded in 1952 and 1953.

During 1953, 1,463 graduates of 175 foreign medical schools and seven licensing corporations of foreign countries were examined by 36 licensing boards. A total of 796 successfully passed the examinations; failures numbered 667, or 45.5 per cent. At no time during the last 24 years did fewer than 30.7 per cent of such graduates fail in a given year, it added.

"This extremely high percentage of failures is a primary factor in the cautious attitude that has been maintained by licensing boards in admitting foreign graduates to the licensing examination," the report said.

The largest number of foreign graduates were examined by New York—450; Illinois examined 411, California 148, and Ohio 105. Foreign trained physicians may apply for licensure to all but 11 licensing boards, according to the report. Most of the boards have stipulations which must be complied with prior to licensure examination.

### Connecticut Heart Association Elections

Dr. Jasper A. Smith of Waterbury has been elected president of the Connecticut Heart Association for the coming year. The new vice-president is Dr. William J. Lahey, director of medical education at St. Francis Hospital, Hartford. Dr. John C. White of New Britain, retiring president, and Dr. Samuel Rose of Stamford have been elected to the executive committee.

The annual meeting of the Association was addressed by Dr. E. Cowles Andrus of Baltimore, president of the American Heart Association.

### Connecticut VA Medical Society

The Connecticut Veterans Administration Medical Society, at its annual business meeting June 3, 1954, elected the following slate of officers for the coming year: President, Julius J. Sachs; Vice-President, Paul M. Sherwood; Secretary, Einar A. Lundberg; Treasurer, Joseph Brandriss.

It was voted that the annual dinner meeting of the Society would be held in November at the Hotel Statler in Hartford.



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## Progress in Clinical Medicine

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### SURGERY OF THE ESOPHAGUS

MAX G. CARTER, M.D., *New Haven*

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*The Author. Chief of Thoracic and Cardiovascular Surgery, Hospital of St. Raphael, New Haven. Attending Surgeon, Grace-New Haven Community Hospital, Consultant in Thoracic and Cardiovascular Surgery to St. Mary's Hospital, Waterbury, Meriden Hospital and Griffin Hospital, Ansonia*

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#### DIAGNOSIS

A discussion of esophageal disorders amenable to surgical therapy may properly begin with fundamental diagnostic considerations. Swallowing is a complex physiologic process which involves protection of the tracheal orifice and reflex initiation of muscular esophageal movements. We often see patients with supposed tumors or fistulae, suspected because the radiologist finds barium entering the trachea, who actually suffer only from neurologic swallowing disorders. Most commonly these are older patients who have had multiple "small strokes."

In addition to the usual careful history and physical examination, one should investigate the gag reflex and then carefully observe swallowing with the fluoroscope. If the patient is given Lipiodol or Idochlorol (to minimize pulmonary inflammation if aspiration occurs) one can see if there is difficulty in initiating swallowing, if the trachea is not protected by the epiglottis, if there is an oropharyngeal diverticulum which fills and overflows, if dye appears in the trachea by spilling directly or passing through a tracheoesophageal fistula, and if the laryngeal cartilages rise normally without fixation during swallowing. The radiologist may then use thin and thick barium for a complete examination. Very thick barium, used with the patient in a variety of positions on the fluoroscopic tilt table, is necessary to determine normal expansibility, particularly of the lower thoracic esophagus. Localized fixation of the wall, even on one side only, suggests carcinoma.

Esophagoscopy should be used freely. It is imperative that this examination be made in all patients with questionable diagnoses, and in all those with a history suggesting esophageal disease in whom the x-ray is negative. A greater possibility of error exists

from the interpretation of shadow pictures than from direct examination. In addition, no patient should be subjected to esophageal surgery without preliminary endoscopy. This policy will occasionally save the surgeon the embarrassment of an obvious misdiagnosis and the patient an unnecessary operation. There is little risk to esophagoscopy when performed by a properly trained surgeon.

Esophagoscopy will occasionally reveal total esophageal obstruction in an adult due to a foreign body, usually meat. This obstruction sometimes occurs because of inadequate chewing due to poor teeth. However, one must always look for narrowing due to underlying cardiospasm, stricture or cancer.

#### CANCER

Absolute cure of esophageal cancer is obtained in relatively few patients. Restoration of normal swallowing and therefore real palliation can be achieved for many.<sup>1</sup>

Dysphagia is a late symptom and patients often give a history of "heartburn," vague substernal distress, or a transient uncomfortable feeling when swallowing solids—all occurring weeks or months before real obstruction becomes apparent. I agree with Garlock that all such patients should have esophagoscopy<sup>2</sup> and we always perform bronchoscopy as well, thus identifying gross tracheobronchial involvement.

The decision for operation and the evaluation of subsequent results require consideration of the site of the tumor, the duration of symptoms, the extent of the lesion, the pathologic cell type, and the severity of other disease conditions present. We must distinguish between operations undertaken for palliation and those intended to cure. In common with others,<sup>1,2</sup> I maintain an aggressive stand toward

esophageal cancer. With a few days preoperative observation blood volume can be restored, fluid and vitamin stores replenished, and pulmonary and cardiac reserves evaluated, thereby making surgery possible.

Lesions of the lower one-third of the esophagus and of the cardiac end of the stomach can be excised with a mortality rate of approximately ten per cent. These operations carry little hospital morbidity and can be made quite radical with small increase in mortality. Cure is rare in patients with adenocarcinoma of the gastric cardia but palliation of one or two years is relatively common. Similarly, epidermoid carcinoma of the lower one-third of the esophagus can usually be resected and excellent swallowing attained, together with a cure rate of about fifteen per cent.<sup>1</sup>

Lesions of the cervical and upper two-thirds of the thoracic esophagus, which require anastomosis above the aortic arch, still produce an operative mortality of at least twenty per cent. Most of these deaths are due to heart disease and other disease conditions present in patients in this age group. Operation is desirable for small lesions in these locations, since cures may be obtained. If the lesion is extensive and hence incurable, I no longer suggest resection. Occasionally inoperability may be determined only at thoracotomy. Surgical resection with anastomosis above the aortic arch, for palliation only, probably does not justify the associated mortality rate.

Swallowing of liquids and semisolids may be maintained in patients with nonresectable lesions at any level by endoscopic polyethylene intubation.<sup>3</sup> This method has been most successful in our hands and, when combined with radiation therapy, dramatic palliation has occasionally been obtained. We have been able to introduce functional polyethylene tubes in fourteen of twenty patients in whom the attempt was made. It is probable that as improved radiation therapy becomes more widely available, still better palliative results will be obtained in patients with nonresectable esophageal cancer.<sup>4</sup>

It is axiomatic that a surgical recommendation presupposes optimum conditions including superior anesthesia and experienced surgeons. Without these, surgery of the esophagus should not be attempted.

I strongly agree with those who feel that gastrostomy increases morbidity without reducing mortality, does not prolong life or relieve distress, and should never be performed in patients with esophageal cancer.

## DIVERTICULA

Diverticula are most common in the upper esophagus where they are of the Zenker type. These are herniations of the esophageal mucosa and submucosa through the posterior constrictor muscles.<sup>5</sup> Such sacs may be asymptomatic when small but inevitably enlarge. They then may produce obstruction to swallowing, gurgling regurgitation of air, offensive breath, reflux drainage when the patient lies down, and sometimes therefore may result in aspiration pneumonia. All cases, except possibly the very small asymptomatic diverticula, should be repaired.

Two stage operations were useful in the developmental phase of this surgery but are no longer required. Operation should be preceded by endoscopic examination of the sac and removal of its contents, and a one stage procedure performed through a transverse collar incision is very satisfactory. It is desirable to excise all of the sac without producing an esophageal stricture, and of course the recurrent laryngeal nerve should be carefully preserved.

Diverticula may occur in the middle one-third of the esophagus, where they are usually of the traction type in association with chronic inflammation in hilar lymph nodes. These are reasonably common but rarely produce symptoms.

Supradiaphragmatic (epiphrenic) diverticula may also occur but are quite rare and usually asymptomatic. Except for infrequent instances of hemorrhage or obstruction by a foreign body, esophageal diverticula of the middle and lower one-thirds do not require surgery. Indeed, surgical intervention even for radiologically large sacs is usually ill advised. I must reemphasize, however, the desirability of removing pharyngoesophageal diverticula to prevent aspiration pneumonia.

## CARDIOSPASM OR ACHALASIA

We now know that the esophagus with cardiospasm not only suffers from contraction of its distal segment but is also deficient in motility. My own experience confirms that of others<sup>6</sup> that careful dilations with a hydrostatic or pneumostatic bag, repeated if necessary at not too prolonged intervals, is the proper treatment for most cases. A few patients, usually not more than twenty per cent, will not respond to this treatment. These, together with those advanced cases with massive esophageal dilatation when first seen, may require surgery. The Heller operation, which sections the muscle fibers of the contracted segment leaving the mucosa intact, is usually the preferred procedure.<sup>7</sup> It is most import-



ant to avoid surgical procedures which create incompetency at the cardia and thereby produce gastric reflux.<sup>8</sup> Ulceration, hemorrhage, and continual distressing esophageal symptoms uniformly plague the patient with the incompetent esophagogastric junction.

#### REGURGITANT ULCERATION AND BENIGN STRICTURE

Peptic esophagitis or inflammation and ulcer may occur in patients with hiatus hernia, persistent vomiting, prolonged gastric intubation, and occasionally may be found in association with apparently unrelated diseases such as pancreatitis, biliary tract disease, and cutaneous burns. Duodenal ulcer is also commonly associated with esophagitis.<sup>8</sup> It is probable that the common factor is an excess of acid gastric secretions which are allowed to bathe the distal esophageal mucosa due to incompetence at the esophagogastric junction.<sup>9</sup>

The frequent association of hiatus hernia with severe esophagitis and the late development of a real stricture is of great importance. It may be very difficult to distinguish a stricture from carcinoma and cancer may occasionally arise in a stricture of long duration. The patient with "heartburn," reflux of fluid into the mouth when lying down, and vague dysphagia (usually occurring first to meat), must always have esophagoscopy in addition to careful roentgen study. Biopsy should be used to exclude cancer.

Most patients with benign esophageal strictures can be managed with a good ulcer regimen in addition to esophageal dilatations performed by a thoracic surgeon experienced in the procedure. A few cases, however, will require transthoracic excision of the strictured segment. Some patients, particularly those whose strictures are not irrevocably fibrous and who have associated duodenal ulcer, can be managed well with subtotal gastrectomy together with esophageal bouginage. The valve-like action of the esophagogastric junction must be preserved if late symptoms of a similar nature are not to occur.

#### HIATUS HERNIA

Diaphragmatic hiatus hernia is not traditionally thought of as an esophageal disorder. It is now quite obvious that this anatomic abnormality predisposes to gastric reflux and esophagitis. I agree with Ingelfinger that all hiatal hernias associated with esophagitis should be repaired.<sup>6</sup> If the condition is of long duration with marked esophageal shortening, complete anatomic restoration may be impossible.

For this reason, hiatal hernias should be repaired before symptoms have become pronounced.

I do not recommend wholesale repair of diaphragmatic hernias incidentally discovered by the roentgenologist. All such patients, however, should have a careful review of their symptoms. Endoscopic examination should be performed if esophageal regurgitation is suspected. All those with esophagitis, even minimal, should have repair. One must of course carefully exclude those patients whose symptoms are due to disorders of the biliary, pancreatic, or cardiovascular systems.

#### ESOPHAGEAL VARICES

Massive hematemesis presents a crisis demanding immediate diagnosis. If esophageal varices are a possible cause, their presence or absence may be correctly determined by direct esophagoscopy which can be safely performed even during a bleeding episode.<sup>9</sup> Bleeding may be temporarily arrested by oxycel tampons, by balloon tamponade, or in cirrhotic patients direct transthoracic ligation of the esophageal varices may be necessary.<sup>6</sup>

Portacaval and splenorenal shunts have great value in controlling hemorrhage from esophageal varices. Consequently, every effort should be made to salvage these patients from the hemorrhagic episode which first brings them to the attention of a physician. All such patients should then have careful evaluation of their suitability for a shunting procedure before they again have an opportunity to bleed.

#### UNCOMMON ESOPHAGEAL DISORDERS

Spontaneous perforation of the lower esophagus occurs rarely but should be recognized because it is always fatal unless surgically treated. The diagnosis usually can be made by history alone. The patient ordinarily has eaten heavily, vomits and then has a sudden devastating pain in the epigastrium with extreme shock and often dyspnea. A chest roentgenogram will reveal pneumomediastinum, almost always left pneumothorax, and frequently hydrothorax. Adequate blood must be obtained, antibiotics given and the rent immediately repaired. The patient may not recover from shock until the operation is nearly complete. Fifty to seventy-five per cent of the cases should recover.

Benign tumors of the esophagus are most commonly leiomyomas. Neurofibromas, fibromas, and fibromyomas are less common. These all may produce dysphagia depending upon their size and location in relation to the esophageal lumen. The



diagnosis is established by roentgen examination and esophagoscopy. Operation for local removal is indicated.<sup>11</sup>

Lower esophageal ring is a recently recognized entity which usually produces minor symptoms, may be responsible for occasional serious obstruction to swallowing, and should be accurately differentiated from other conditions since surgery is not often indicated.<sup>12</sup>

Collagen diseases such as scleroderma may involve the esophageal wall, diminish motility and produce symptoms mimicking cardiospasm or benign stricture. Diagnosis is made by establishing the presence of the generalized disorder with local esophageal confirmation by both esophagoscopy and roentgenography. If there is difficulty in swallowing, gentle bouginage will almost always give relief. Surgery should not be attempted.

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## The State Committee on Trauma of A.C.S. Reports



HAROLD W. WELLINGTON, M.D.

As arranged under the leadership of Harold Wellington of New London, The Connecticut Regional Committee on Trauma of the American College of Surgeons had its second meeting of the year at the Lawrence and Memorial Associated Hospitals in New London April 14, 1954.

The meeting lent itself extremely well to training for disasters, particularly those with atomic weapons. Dr. Wellington, the local chairman, had an excellent demonstration of orthopedic appliances and techniques. Frederick Hartman presented an up-to-date discussion of tetanus with two case reports, and an excellent review of modern treatment of thermal burns was presented by Malcom Ellison with case demonstration. A. Duncan MacDougall, medical director of Electric Boat, Division of General Dynamics Corporation, and David Smith, Ph.D., health physicist, then walked the tightrope between restricted and essential information in presenting the industrial program with problems involved in the use of nuclear power. This was followed by a demonstration of the instruments used in the detection of radioactive material and the extensive labora-



tory setup for prophylaxis and treatment of contamination at the Electric Boat plant hospital.

It is hoped that during the following year this program can be made available to every physician in Connecticut.

Benjamin B. Whitcomb, M.D.

On Saturday, February 13, 1954, the Waterbury Hospital was host to the members of the State Trauma Committee interested in trauma. The topic "Abdominal Trauma" was offered. Four cases of unusual abdominal injury were presented by the hospital staff, and were well discussed.

Lt. Richard C. Karl, assisted in unusual and sympathetic fashion by his Commander R. N. Grant of the St. Albans Naval Hospital, presented a review of the care of the wounded under their supervision in Korea. Colored movies emphasized the fact that should combatants survive the first insult of injury, their chances of recovery were excellent. They demonstrated the benefit of intelligent, positive, first aid treatment, rapid evacuation, prevention of shock and infection, and even the use of arterial grafts in extremities from an artery bank in the treatment of the wounded soldier as he passed through the chain of evacuation. The discussion which followed, in which most of the sixty men in attendance took an active part, was very lively. Luncheon was served by the hospital administration. It was agreed that this had been a fine meeting.

Royal A. Myers, M.D.

On September 16, 1954 an afternoon meeting of the September Clinical Congress at New Haven will be sponsored by the Trauma Committee covering the subjects of burns, traumatic surgery of the hand, and the treatment of traumatic swelling. The speakers will be outstanding and the presentation up to date.

On October 14, 1954 a meeting will be held at the Greenwich Hospital under the leadership of Dr. Howard Serrell.

### 31ST CONVENTION

National Society for Crippled Children and Adults, Hotel Statler, Boston, Wednesday, November 3, through Friday, November 5, 1954.

A meeting of international importance which will bring together authorities in all the fields of work relating to rehabilitation of crippled children and adults.

## American College of Gastroenterology Absorbs National Association

At a special meeting held in New York City recently final steps were taken to transfer the membership of the National Gastroenterological Association to the American College of Gastroenterology. A transfer of all the assets including the official publication, *The American Journal of Gastroenterology*, to the college was voted upon.

The college will hold its 1st Convention in Washington, D. C., October 25, 26, 27, 1954 in conjunction with the 19th Annual Convention of the National Gastroenterological Association.

## Psychiatrists Needed By VA

More psychiatrists are needed for Veterans Administration mental hygiene clinics to prevent expensive hospitalization for the increasing load of service connected psychiatric cases, VA has announced. VA said its mental hygiene clinics are able to treat certain types of psychiatric cases at a cost of 70 to 80 per cent below that of hospitalization in even the most economically operated hospitals. As a result, VA estimates its clinics now save more than \$2,000,000 a year in money that would be required if the clinic cases had to be hospitalized.

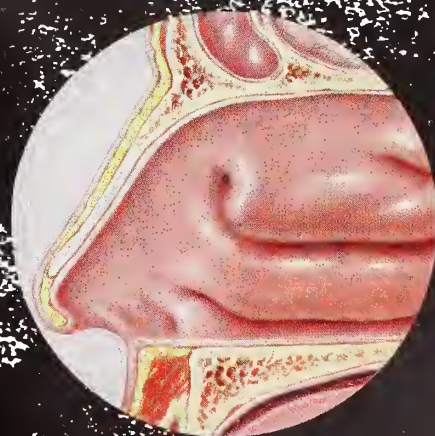
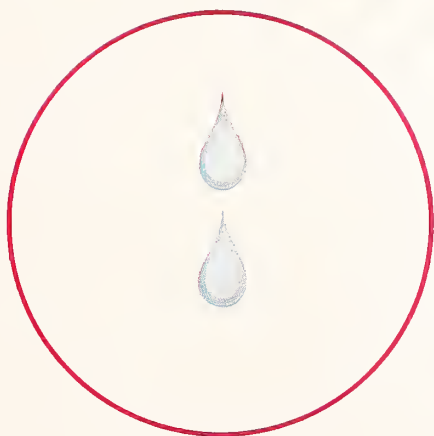
Service connected cases are the only group of veterans entitled to both outpatient clinic care and hospitalization; and approximately 500,000 veterans are service connected for psychiatric and neurologic disabilities. By treating more of this load in clinics, the need for expensive hospitalization among the service connected psychiatric cases may be reduced proportionately. Moreover, these clinics enable VA to shorten the hospitalization of service connected cases whose hospital treatment can be completed on an outpatient basis.

Another advantage of the clinic program, according to VA, is that it permits the treatment of service connected veterans in or near their home communities without loss of time from work. This is of particular value to veterans and their families, VA said.

VA said it has openings for psychiatrists who prefer to work with outpatients or who are interested in organizing or administering mental hygiene clinics.

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ulcer, right leg,  $1\frac{3}{4}'' \times 1\frac{1}{4}''$ ;  
ulcer, left leg,  $\frac{1}{2}'' \times \frac{1}{2}''$ .

With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



**HYPERTENSIVE ISCHEMIC  
ULCER** of right leg in patient

age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA  
BY COURTESY OF R. J. LOWENBERG, M.D.,  
CONSULTANT IN VASCULAR SURGERY,  
CONNECTICUT STATE HOSPITAL,  
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C I B A



## THE PRESIDENT'S PAGE

### WORDS, WORDS, WORDS

This is being written on a glorious May day when the weather is perfect and Connecticut is enchanting in her beautiful garments of dogwood and apple blossoms. But unless better judgment prevails it will appear in July, when the heat and humidity may increase the difficulty of beguiling members into considering the topics usually discussed on this page. Surely anyone who will read medical journals in hot weather should be rewarded by something more diverting than articles upon medical politics or ethics. So you are invited to consider for a moment the endless fascination and delight to be found in words for their own sake—in their origins, earlier meanings, and developmental changes.

To consider a few medical terms first, how many of us remember, or ever knew, that the word *sacrum* was originally *os sacrum*, the sacred bone, because it was used in sacrificial rites? How many realize that *pylorus* is taken almost bodily from the Greek *pyloros*, meaning watcher of the gate? It might possibly sharpen your interest in the procedure if you remember that the word *autopsy* means literally to see for ones self. *Duodenum* was originally *duodenum digitorum*, of twelve fingers, referring to the length of this portion of the intestine. Arteries were given this name by the early Greeks, who observed that there was no blood in them after death and concluded that during life they must have carried air. The word *artery* means windpipe. The carotid arteries have been so designated for several thousand years, because the Greeks, observing that simultaneous pressure upon both of them would lead to faintness or unconsciousness, called them the *karotides*, from the verb meaning to stupefy.

Nausea comes logically from *naus*, ship, as this distressing symptom was first identified with seasickness. But *paregoric* has a less obvious origin. The early Greeks were accustomed to meet in the *agora*, or marketplace (whence *agoraphobia*) and in time the word *agora* came to mean an assembly. At such assemblies speeches were sometimes made to comfort the people or raise their morale. Ultimately a word (*paregorein*) was coined, meaning to exhort the public, and from this was derived the adjective *paregori*, meaning comforting or soothing. Few public exhortations today are comforting, but at least they often induce drowsiness.

Nicotine is a word known to millions, but how many know that it immortalized the man who first introduced tobacco into France in 1560? His name was Jacques Nicot.

Those who have cereal for breakfast might relish it more if they recall that the name is from *Ceres*, goddess of the harvest. Mention of *Ceres* inevitably calls to mind the fascinating legends of *Prosperine* and *Pluto*, the Eleusinian mysteries, and the numerous myths relating to the sowing of the seed and the gathering of the harvest.

It is probably safe to say that although brassieres are known to all women and to every man who has seen a bathing resort, musical comedy, or modern magazine, not one in a thousand knows its origin. It is from the old French *brase*, meaning arms (thus to embrace is to take into one's arms). Originally the word meant a support, and was applied to the garment worn by a mother to support her baby. It retains its original meaning, but the application has changed remarkably.

Finally, any of you who are irritated by the sudden unexplained behavior of your wives and daughters (or women in general) may find wry comfort in the reflection that the words *capricious* and *caprice* are derived from the word meaning goat, the lively animal that suddenly leaps about with no apparent reason or purpose. The island of *Capri* is said to have taken its name from the large number of goats found upon it by the early settlers.

Lest some generous friend think that the above facts were drawn at random from a well stocked mind, let me confess at once that they were dug out of dictionaries available to all.\* But the digging was great fun, and is heartily commended to all who share my dislike for the more conventional form of that exercise.

H. M. Marvin, M.D.

\*Especially Shipley's Dictionary of Word Origins, to which I am indebted for much of the above and for hours of delightful entertainment.



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## THE HISTORIAN'S NOTE BOOK

### A CASE OF CATALEPSY

ARTHUR S. BRACKETT, M.D., *Riverside*

WILLIAM BARNWELL, M.D. was living in Philadelphia in 1793 gathering material for a book "Physical Investigations and Deductions" which was published in Philadelphia in 1802. He says at the end of a report on a case of catalepsy, "This I believe was a true catalepsy and as it is a rare disease which many medical gentlemen never have a chance of seeing, I thought it to be my duty not to suffer it to be lost. It was the only case I had ever seen."

On the first of August (1793) he was called to see a Mrs. Cooke at 8 P. M. living at No. 78 South Third Street who had every appearance of being dead. . . . Moderately plethoric, she had been married but had no children. When he first saw her she was lying on a bed without any appearance of life or motion. As she had no pulse or evidence of life, most around her thought her dead. When her arms or legs were moved, they would remain in the same position.

His treatment was to apply snuff to her nose and try to pour spirit of hartshorn down her throat. They shook her and rubbed her hands and wrists and temples with spirit of hartshorn. By this time he had been with her half an hour. Then he "hit on the only plan which would have aroused her"—an emetic of tartar emetic, two grains, and six or eight of ipecacuana and forty drops of volatile aromatic spirit in a spoonful of water which they finally managed to force down her throat. In half an hour she vomited, gradually became conscious and complained of a sense of suffocation. She had been unconscious a total of three hours.

August 2. She complained of great pain and as she had been laboring from an obstruction of the catamenia, she was bled 10 oz. of blood and given half an oz. of Rochel salts and an antimonial draught with a few drops of laudanum.

August 3. The pain was alleviated.

August 4. She complained of great oppression and lassitude for which she had the saline mixture with

volatile aromatic spirit, forty drops, and antimonial wine, twenty drops, every six or eight hours.

August 5 and 6. The above was repeated.

She gradually grew better and remained so except for some hysteria and nervousness.

### Twenty-Seventh Anniversary Numbers of the Hebrew Medical Journal

*The Hebrew Medical Journal* completes its twenty-sixth year by issuing two volumes in 1953 under the editorship of Moses Einhorn, M.D. of New York. Written in Hebrew, with English summaries, the *Journal* has played an important part in the creation of a medical literature and terminology in the language of the Bible. Such a terminology represents an important linguistic and scientific achievement and materially accelerated the rise of a medical literature in Hebrew. To this literature, *The Hebrew Medical Journal* is also making substantial contributions.

Among the articles in the Spring issue, Volume 1, 1953, is the section on "Israel and Health." Dr. Meir Yoeli of the Hebrew University in Jerusalem presents a treatise on "Tropical Diseases in Israel." Another contribution of interest is the manuscript of a medieval Hebrew treatise on "Melanchely" (12th Century), with valuable notes and commentary, by Zussmann Muntner, M.D. of Jerusalem.

In the Fall issue, Volume 2, 1953, is the paper by Dr. Edward Tolstoi on "Treatment of Diabetes Mellitus by the Clinical Approach." In this number is included a symposium on "Artificial Insemination." In the section called "Israel and Health," Dr. A. A. Schwarzbart deals with the increase in the number of tuberculosis cases, which followed the huge influx of newcomers from culturally and economically backward countries after the establishment of the State of Israel, and reports on the success achieved by the treatment of the malady with antibiotics.

## NEWS FROM WASHINGTON

### DOCTORS EXCLUDED FROM SOCIAL SECURITY

**HR7199—Social Security Extension.** (Reed, New York.) On May 25 the House Ways and Means Committee completed action on the administration's social security extension bill and voted to report it favorably to the House. For the medical profession, the most significant change was the committee's reversal of its position on the compulsory coverage of physicians. In an earlier vote on May 19, reported as 12 to 8, the committee agreed to force coverage on physicians. After receiving a flood of telephone calls and wires from state medical societies and individual physicians, the committee reconsidered the action and by a vote of 15 to 10 (the full membership) decided not to extend coverage, either compulsory or voluntary, to physicians, interns or student nurses. It also exempted policemen and firemen. It is estimated that under the bill, as approved by the committee, coverage would be extended to about 9 million more persons, rather than the 10.5 million asked for by the administration. Among other changes in the present law, the bill would liberalize benefits, increase the amount of allowable earned income without sacrifice of benefits (from \$75 per month to \$1,000 per year), increase from \$3,600 to \$4,200 the amount of income subject to OASI payroll taxes and provide "waiver of premium" to protect the ultimate pension rights of permanently and totally disabled. The benefit increases for presently retired would range from \$5 to \$13.50; those retiring in the future would receive as high as \$23.50 more than at present. The committee added a new section continuing for another year, beyond September 1, the present federal-state matching formula for old-age assistance grants to states.

### Senate Committee Changes in Hill-Burton, Rehabilitation Bills

The Purtell health subcommittee of the Senate Labor and Public Welfare Committee made these major changes in the Hill-Burton and the vocational rehabilitation expansion bills (HR8149 and S2759),

changes that are in keeping with American Medical Association recommendations:

#### HILL-BURTON CONSTRUCTION

States would be given considerable leeway in use of funds in any one of three categories: hospitals for the chronically ill, nursing homes, and diagnostic and treatment centers. In the case of vocational rehabilitation centers, however, states would have to use the funds so earmarked. Finally, clarifying language was written on diagnostic and treatment centers to make certain that funds would go only to diagnostic centers or diagnostic and treatment centers, thus denying benefits to facilities set up for treatment alone.

#### VOCATIONAL REHABILITATION

Language was changed to reassure states they would suffer no reduction in federal matching funds by virtue of the new formula proposed, this assurance to be given for at least five years.

### President Entertains Life Insurance Group at Luncheon

A group of 17 life insurance officials indorsed the "general objectives" of the administration's reinsurance plan following a luncheon at the White House. Present with the insurance executives were President Eisenhower, Secretary Hobby, Under Secretary Rockefeller and Assistant Secretary Perkins. According to the committee staffs, none of the life insurance group testified at the extensive Senate and House hearings on the reinsurance bills, which now are awaiting action in the Senate Health Subcommittee and the House Interstate and Foreign Commerce Committee.

The reinsurance idea was opposed by spokesmen for health insurance interests and by state insurance commissioners at both hearings. After the White House meeting, the life insurance executives issued the following statement:



"During our conference with the President there was a general expression on the part of the life insurance company representatives who were present favoring the general objectives of the bill. We believe the measure is directed toward encouraging and stimulating still further the development and expansion of health insurance services and coverage for the American public through voluntary plans. There was discussion at the conference as to how the bill may be improved. The plan includes many sound insurance principles. We feel that provisions in the bill dealing with the utilization of state insurance departments under the plan may be further strengthened in order that they may be used to the maximum extent and that the system of state supervision of insurance should not be limited by federal activity in any field."

A representative of the insurance group said the statement would not be enlarged upon, that it would "have to speak for itself."

### Administration Recommends ILO Convention Not Be Approved

The Eisenhower administration has forwarded to Congress, with a recommendation that it not be ratified, the International Labor Organization's convention on minimum standards of social security. The convention, adopted by ILO in 1952, has caused concern in medical and other groups. It covers nine fields: medical care, sickness benefits, unemployment benefits, old age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. A government is considered to have ratified the convention if it promises to meet the requirements in three of the nine fields.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: (a) a system of compulsory health insurance, (b) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (c) private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

In transmitting the convention to Congress, the President said it "is . . . regarded as not suitable for ratification but rather for referral to the appropriate federal and state authorities for their

consideration." An accompanying summary of comment from all affected federal departments and agencies pointed out that federal laws already are in accord with two of the points, old age insurance and survivors insurance. On the other points, the agencies came to the same conclusion as the President, namely that these issues are within the jurisdiction of state governments, and "that therefore the convention is not appropriate for ratification" by Congress. The summary also noted that while signatories to the convention agreed to bring it before their respective legislative bodies, "it is entirely within the discretion of the competent authority of each country to determine whether any legislation is to be enacted."

The brief was concurred in by Commerce, Interior, Justice, Labor, Navy, and Health, Education, and Welfare Departments, and by the Civil Service Commission.

### House Group Approves Doctor Draft Law Change

Following a brief hearing recently, Arends subcommittee of House Armed Services Committee voted approval of S3096. This is the bill, which Senate already has passed, permitting utilization in enlisted status of doctor draft inductees who fail to qualify for, or refuse to accept, commissions. Although a few subcommittee members expressed anxiety that the amendment might be applied unfairly in some instances, enactment is anticipated. In this regard, Assistant Secretary of Defense John A. Hannah testified:

"The Department of Defense would prefer not to have physicians and dentists serving in an enlisted capacity. However, we do not believe that this committee or the Congress wants to have physicians and dentists of this type avoid service and have good loyal physicians and dentists who have no such (security-doubtful) background be called from a higher priority to fill their assignments."

" . . . every physician and dentist who is qualified will be offered a commission commensurate with his professional experience unless he is found unsuitable for security reasons or he himself rejects the tender of a commission." Note: Presently on active duty in enlisted ranks are seven physicians and dentists, out of a total of 65 inducted as privates since doctor draft law became effective in 1950.

## Navy and Air Force Put in Call for 850 Physicians

Selective Service headquarters received requisitions in June for 850 physicians, 500 for Air Force and 350 Navy. President Eisenhower has approved the callup. All 850 will be replacements intended for activation in fourth quarter of current year, which means they will be getting their draft notices within 60 days since it takes nearly three months now to complete security clearance prior to commissioning. Navy's allotment of 350 is exclusive of the 480 processed by SS in June and July for that military branch.

Navy's June-July consignment is expected to wipe out Priority I on the doctor-draft eligible roster. The succeeding callup will practically exhaust Priority II and draw heavily on younger ages in Priority III. Meantime Army is about to tap its Reserves for 233 medical officers and some 200 dentists. Former group will be drawn from Priorities I and II, also Priority III-type doctors born on or after August 31, 1925. The dental picks will come from Priority III-type pool born since November 1, 1919.

Shortage of doctors in Navy is growing so acute that Surgeon General Lamont Pugh is ordering dependent care retrenchment: reduction of elective surgery, elimination of well baby clinics, and cutting down on refractions and tonsillectomies, among them.

## Senate Committee Drops New Health Insurance Tax Rule

The Senate Finance Committee has dropped from the tax revision bill a provision that insurance representatives claimed would impede the growth of voluntary health plans. Under present law, an employee pays no tax on accident or health benefits paid under an insurance contract, but does pay tax on benefits coming directly from his employer. As passed by the House, the bill would not differentiate between payments under a contract and direct payments from an employer, but would require that plans "qualify" with the Internal Revenue Bureau for tax exemption. Two of the requirements would be that the worker have a definite right to the benefits, and that there be no discrimination among workers in coverage. The Senate committee eliminated the requirement that plans be screened and approved by the Bureau but left in the section making direct payments from the employer eligible

for tax exemption. Insurance spokesmen, in protests to the Senate committee, had pointed out that smaller plans would have administrative difficulty in complying with the "qualifying" requirement.

## Senators Favor Easing of Tax on Fellowships

Senate Finance Committee has approved income tax exclusion of fellowship stipends up to \$3,600 a year. Tax revision bill is still under committee consideration but this section of it (No. 117) has been disposed of. As was expected, committee indorsed action of House in dropping medical expense base-line from 5 to 3 per cent. Liberalization of Section 117, in comparison with House version, is in recognition of protests and warnings that otherwise there might be a serious decline in applications for scientific study grants.

Since the issue, from standpoint of revenue loss, is of minor importance and Treasury Department does not object to liberalized plan, ultimate adoption is practically certain. Senate committee version of Section 117 (b) (2) provides that stipends of up to \$300 a month are excludable from income for a maximum of three years. This is conditional upon the grantor's being a tax exempt organization or an agency of Federal government.

## Physiometer in Surgery is Demonstrated

A special demonstration has been held at National Bureau of Standards of a physiological monitor which has been developed at NBS under sponsorship of Veterans Administration. The electronic device, which reportedly has undergone preliminary trials successfully, automatically records changes in blood pressure, heart beat and respiration of patients during surgery. The model monitor is to be subjected to continued trial at the veterans hospitals in Washington and Richmond, Virginia.

## WHO Assembly Votes Increased Budget Over U. S. Protests

The 7th World Health Assembly has voted a \$9.5 million budget for World Health Organization programs for 1955. This is an increase of \$1 million over this year but \$800,000 under the recommended figure. Delegates voted approval at Geneva after turning down a U. S. proposal that the budget be held to \$8,607,000. According to a Pan American Sanitary Bureau account of the meeting, Dr. Fred-



erick J. Brady, head of the U. S. delegation, declared the U. S. was strongly opposed to any budget that would bring this country's contribution beyond the \$3 million ceiling set by Congress.

Dr. Brady said that this country does not want to find itself "forced into a position of having to depart from a long tradition of faithfully honoring such obligations." The U. S. contribution to WHO has been running around a third of the total budget.

### Civil Defense Stockpiling 200 Bed Portable Hospital Units

As part of its emergency medical supply stockpiling program, Federal Civil Defense Administration has ordered 200 portable hospital units of 200 bed capacity, and another 90 are on order for states and cities under the matching program (the state pays half, the federal government the other half). Each unit costs \$26,435.47. The first prototype has been on display in Washington for inspection of the public and government officials.

Patterned after the successful mobile Army surgical hospital unit which operated near the front lines in Korea, the FCDA hospital is designed to provide early hospitalization of seriously sick and injured as close as possible to a stricken area.

A complete hospital may be transported in a single van, weighs about 13.5 tons and consists of 450 separate packages and crates. Thirty trained and semitrained auxiliaries can set it up in four hours. FCDA estimates the hospital would require a team of 10 physicians, 20 nurses, 125 trained auxiliaries such as nurses aides and 75 untrained personnel. Equipment includes five folding operating tables, portable x-ray unit and 200 folding canvas cots.

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### Student AMA Growing

The Student American Medical Association held its best and largest annual meeting in May. Fifty-seven delegates participated in the house of delegates sessions and the registrations for members and guests reached almost 1,000. Nonservice connected medical care of veterans, the use of dogs in medical research, and a minimum intern pay scale of \$100 per month, and federal military medical scholarships were among the subjects introduced in the house of delegates.

### The Joint Conference Committee of Dentistry, Medicine and Pharmacy

This important committee actually consists of two conference panels, one representing the Connecticut Medical Society and made up of eight physicians appointed by the President of the Society, the other made up of eight Pharmacists appointed by the President of the Connecticut Pharmaceutical Association. In 1953, both of these professional panels voted to invite appointees of the State Dental Society to active participation. Thus, for the first time since the organization was conceived, it consisted of representatives of Medicine, Pharmacy and Dentistry, at an official level.

It was in the year 1941 that the State Medical and Pharmaceutical associations felt an imperative need for an improvement in mutual understanding between pharmacy and medicine. This action was motivated because the leaders at that time were disturbed over the tragic paradox which existed, namely, the increasing growth of pleasant relations on an individual level between pharmacist and physician, and a widening rift between representative organizations of both these professions.

A committee met and discussed the problem at great length. It was attempted at that time to anticipate all possible ramifications. Alas, it could not be possible to realize the the multitude of problems which would beset us at that time. However, a series of rules and regulations were formulated. Unfortunately, due to the national emergency, this committee became inactive but before adjournment, their thoughts were placed on paper. It was this beginning in 1941 which led to the formation of the first official committee in 1946. According to the rules, the committee conducted its own reorganization and election each year. It was agreed that a member of the Medical panel would serve as chairman, and that a member of the Pharmaceutical panel would serve as secretary of the group. The first chairman of the Joint Conference Committee was Dr. Stanley B. Weld and the first secretary was Louis Kazin. In 1947 Dr. William Salter of the Yale School of Medicine served as chairman of the group and in 1948, Dr. Barnett Greenhouse of New Haven, nationally known authority on diabetes, was elected chairman. Dr. Greenhouse has served continuously since that time and each year he has been unanimously re-elected chairman, a post he still holds with great talent.

When Louis E. Kazin resigned as secretary of the Committee to go to a new position at Rutgers University as Extension Director, Raymond E. Mercier of Plainfield was elected to fill the office of secretary. Mr. Mercier served capably in this position until he was elected president of the Connecticut Pharmaceutical Association, when he resigned, because he felt that he could not do justice to two such important assignments. The members of the committee then appointed Francis B. Cole, secretary, and he still serves in that capacity.

In choosing the membership to this group, both associations seek to select men of proven ability and dependability. It is also important that all sections of the State be represented. The reason for this should be obvious since problems vary in different parts of the State. The committee meets four times a year and usually has a full agenda of matters referred to it by local associations as well as other departments of the State government dealing with problems of public health. The decisions of this group have been sought in several advisory problems which have resulted in extremely important discussions. It is important to bear in mind that the Joint Committee has no power of enforcement. However, its recommendations carry such weight that it is most influential and carries much prestige with all officials concerned. The group usually considers a problem and gives each member an opportunity to discuss the various angles and also to inject a personal opinion. Eventually a recommendation is voted, and it usually is very seriously considered. The outcome and final action is taken at the proper level by the proper officials. The chairman of the Committee has the power to call a special emergency meeting at any time and both panel members usually make every possible effort to be present since the material under discussion is so interesting. Now that the dentists also have membership it goes without saying that they also look forward to the meetings with interest.

Probably one of the more important accomplishments of the Joint Conference Committee was the establishment of the subcommittee, which has gained national recognition, and which is known as the Connecticut Committee on Foods, Drugs, Cosmetics and Devices. This group represents the following agencies: Connecticut Agricultural Experiment Station, Connecticut State Dental Society, Connecticut State Medical Society, Connecticut Pharmaceutical Association, Connecticut Veterinary Medi-

cal Association, The University of Connecticut, The University of Connecticut College of Pharmacy, The Connecticut Drug Commission, and the Yale School of Medicine. Dr. Harry Fisher has served this committee as secretary-treasurer and has done an outstanding job. One can easily see how such a distinguished group can be correlated so as to be in a position to contribute a great deal to the progress of public health in Connecticut. This committee meets regularly and often call into their discussions, high ranking officials from various state agencies for their opinions on a given problem. Its opinions, on the other hand, have been sought in many cases by state agencies which are at a loss to know how they should proceed.

Although the national emergency necessarily limited its activities, it was a foregone conclusion that its reactivation depended only upon the cessation of hostilities. When President Ralph Gentile recommended to the Pharmaceutical Association that they reestablish the Joint Conference Committee as a working group, he found willing cooperation from all those who had been connected with it in the past. At that time President Gentile thought that it might be well to try and tie in the local pharmaceutical associations with the parent committee. However, this did not materialize and after some effort to that end, the Joint Committee abandoned that plan because it was too unwieldy. The present method of procedure, where problems are directed to the Joint Committee chairman directly, is working out very satisfactorily.

In any report on the Joint Conference Committee it would be absolutely unpardonable not to mention the name of Pharmacist Paul Kunkel. To begin with, Mr. Kunkel was one of the first men in Connecticut pharmacy who fought to establish and maintain this committee through its infant years. Not only that, but each year he was the host to a summer meeting at his country estate outside of Waterbury. Each year, the members of the Joint Committee were invited to an excellent outing with their wives and were treated to a dinner, fresh air, and more exercise than probably was wise.

A discussion of the numerous and varied questions which have come before the Joint Conference Committee since its inception, would be so voluminous that it would not be practical in this thumb nail sketch. The continuance of any committee by the State Medical and Pharmaceutical executive committees throughout these many years only serves to



emphasize the value and reputation of the Joint Conference Committee.

The following men have had the honor of serving on this committee:

#### PHYSICIANS

Burdette Buck, Hartford; George Buckout, Bridgeport; Barnett Greenhouse, New Haven; Martin I. Hall, Bristol; Benjamin Katzin, Torrington; Walter J. Keefe, Hartford; Alfred Labensky, New London; W. Holbrook Lowell, Hartford; Fritz Myer, Bridgeport; Allan Poole, New Haven; William Salter, New Haven; Philip Schwartz, Middletown; W. B. Smith, Wethersfield; Louis Soreff, East Hampton; William Wener, Norwich; Stanley B. Weld, Hartford; Thatcher W. Worthen, Hartford.

#### PHARMACISTS

Felix Blanc, Hartford; Daniel Camillieri, Hartford; Francis Cole, West Hartford; Sidney Curran, New Britain; Moses Doyle, Torrington; Nicholas Fennedy, Hamden; Alice Esther Garvin, New Haven; Ralph Gentile, Fairfield; Louis E. Kazin, Bridgeport; Paul Kunkel, Waterbury; Raymond E. Mercier, Plainfield; Jack Malley, Hartford; Edward Mogul, Bridgeport; John Nolan, Norwich; J. Arthur Pelchar, Torrington; Fiore Petricone, Torrington; Benjamin Smith, New Haven; Philip C. Varnum, Glenbrook; Dominick S. Zito, Hartford.

#### DENTISTS

Jack R. Bourke, East Hartford; Alfred J. Gengras, Jr., Hartford; Frederick S. Harold, New Haven; James P. Lawlor, Waterbury; Gilbert LeVine Mellion, Rocky Hill.

The secretaries of each state organization are ex-officio members of the Joint Conference Committee. Since the admission of the dental panel, the committee has voted to balance the group next year by having five members from each association. This will result in a more wieldy group and a smaller number, which will result in a substantial savings, without cutting down on the efficiency of the committee.

Much of the credit for the success of the Joint Conference Committee is due to its present chairman, Dr. Barnett Greenhouse. It was not long after he became associated with the group that Dr. Greenhouse began to realize what tremendous value it offered to both the medical and pharmaceutical professions. As he became more involved, he expressed

a personal desire to resign as chairman, but it fell on deaf ears, as the other members of the group leaned upon his tact and wisdom in the various deliberations. As the prestige of the committee grew and its importance became stronger, the good doctor was reluctant to turn over the chairmanship to any person who did not really want to accept it. Since no one on the panel signified their desire to take the chair in his place, Dr. Greenhouse continued to serve at great personal sacrifice. In recognition of his excellent service, devotion, and the quality of his leadership, the Connecticut Pharmaceutical Association at its recent mid-winter convention, presented Dr. Barnett Greenhouse with a "special achievement award" made expressly for the presentation. It was presented by Francis B. Cole, secretary of the Committee in the name of the Pharmaceutical Association, and was one of the features of the convention program.

*Reprinted from Connecticut Pharmacist, April 1954, by permission of the editor*

## LETTERS TO THE EDITOR

### Young Men's Christian Association of Greater Hartford

April 26, 1954

Mrs. Dewey Katz, President  
Connecticut State Medical Auxiliary  
140 Fern Street  
Hartford, Conn.

Dear Mrs. Katz:

We have just received a notice that the Connecticut State Medical Auxiliary will supply the YMCA with a year's subscription to *Today's Health*.

We appreciate this very, very much and know that it will be beneficial, not only to our members but to the staff as well.

Sincerely,  
F. E. Gray,  
General Secretary

#### EDITOR'S NOTE

Through the suggestion of a former counselor at Camp Jewell, the Hartford "Y" camp, the Woman's Auxiliary is supplying the reading room of every YMCA in the State with a complimentary subscription to *Today's Health*.

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## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

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William G. H. Dobbs, Torrington  
*Chairman*

Harold J. Bergendahl, Norwich

Burdette J. Buck, Hartford  
James C. Canniff, Torrington  
Morris A. Hankin, New Haven

Harry C. Knight, Middletown  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

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### New PR Service Kits

When committees of local medical societies meet to consider development of community services, one of the first needs is information concerning the experiences of other groups.

Recognizing this need, the Society's Committee on Public Relations has for some time sponsored the collection of such information in service kits. These have been made available to local committees on a loan basis and have proved highly valuable in a number of instances.

The American Medical Association's Public Relations Department has recently completed collection of additional information concerning four community activities, emergency medical call plans, health forums, television and mediation committees. This information has been compiled in file folders for ready reference and is also available for loan through the office of the State Medical Society.

These kits and those maintained at the State level contain special reports, surveys, news clippings and photographs, magazine reprints, statistical data and other information concerning the services to which they pertain.

The purpose of the kits is to make a library of current information on the experiences of medical associations readily available for local committees. Much time and duplication of effort can be saved by using this service.

### New Haven County Sponsors Health Forum

A public medical forum on heart disease was attended by more than 150 Cheshire residents the evening of June 2 in the auditorium of the Cheshire High School.

Physicians who participated in the presentations and question period that featured the event were H. M. Marvin, New Haven, president of the State Medical Society; Jasper A. Smith, Waterbury, vice-president of the Connecticut Heart Association, and

William W. Glenn, attending surgeon, New Haven Hospital. Moderator of the forum was Dr. William E. Neff, Jr., of Cheshire.

The event was sponsored by the Rotary Club of Cheshire, in cooperation with the New Haven County Medical Association and the Waterbury Heart Association. The forum was the first to be held in New Haven County under medical association sponsorship since 1939, when a series of six forums was sponsored by the Waterbury Medical Association. Although little information is available concerning these early forums, it is known that they were well attended and that the programs comprised a presentation by a principal speaker and discussions by two local physicians.

### Emergency Leaflet Distributed to Highway Department Employees

A thousand copies of the Society's new brochure on emergency services sponsored by local medical associations have been requested by the State Highway Department for distribution to its employees.

The three-page publication lists the telephone numbers and sponsoring associations of the 15 major emergency call plans throughout the State. It also contains information concerning reasons for establishing the plans and how they may be used in a medical emergency. Besides distributing the leaflet to employees, the Highway Department plans to post copies of it on the 300 bulletin boards at maintenance stations in various parts of the State.

### Medical Association Guidance for Program Chairmen

County medical associations may soon receive requests from the program chairmen of women's clubs for assistance in developing health programs as a result of the recent distribution of a kit of program materials by the American Medical Association.



The kits were distributed at the recent 63rd Annual International Convention of the General Federation of Women's Clubs. They contain outlines for five health programs, as follows: "Crisis in the Kitchen" (overweight); "They Gamble With Your Life" (medical quackery); "Helping Husbands Live Longer" (growing old gracefully); and "Medical Care—And How to Pay For It" (medical costs and health insurance).

Lists of films and health publications pertaining to the five programs are also included in the kits. Program chairmen are advised to contact local medical associations when requesting physician speakers for the programs.

### Wheeler Pavilion

The Gaylord Farm Sanatorium at Wallingford, Connecticut which for more than fifty years has been caring for patients with tuberculosis, is extending its semiprivate, nonprofit, medical service to patients with cardiac disorders. Gaylord's cardiac program was developed from the recommendations of a State wide Medical Advisory Committee under the chairmanship of Dr. A. Bliss Dayton of New Haven. Members of this Committee are:

Paul B. Beeson, M.D., Yale University, New Haven; Courtney C. Bishop, M.D., New Haven; Ira V. Hiscock, Sc.D., Yale Department Public Health, New Haven; Gustaf E. Lindskog, M.D., Yale University, New Haven; Thomas P. Murdock, M.D., Meriden; William S. Maurer, M.D., Willimantic; W. Bradford Walker, M.D., Torrington; Charles Lewis Fincke, M.D., Stamford; James Raglan Miller, M.D., West Hartford; Arthur J. Geiger, M.D., New Haven; Maxwell O. Phelps, M.D., Hartford; John H. Foster, M.D., Waterbury; Edwin R. Connors, M.D., Bridgeport; Francis Braceland, M.D., Hartford; John Donnelly, M.D., Hartford; Benjamin White, M.D., Hartford.

The recommendations of Gaylord's Medical Advisory Committee were:

1. Adapt Gaylord's services to meet the changing medical care needs of Connecticut residents particularly in regard to cardiac and other pulmonary disorders.

2. Add those professional skills necessary to provide top quality care.

3. Adapt one or more of Gaylord's buildings to make suitable separate quarters for patients with cardiac and nontuberculous pulmonary disorders.

The ultimate aim of Gaylord's cardiac program is to channel all phases of medical care to the patients' individual needs and establish a target point of maximum restoration. All of these comprehensive services will be directed toward this goal.

The following is an outline of the type of care to be given:

- I. Medical re-evaluation as necessary by our medical staff and consultants to establish a target point of a patient's maximum physical restoration.

- II. Medical management to direct all services towards the target point: Prescribed medication; prescribed diet; graded activities; physical medicine; health education.

- III. Nursing care.

- IV. Social service.

- V. Vocational guidance and training.

- VI. Occupational therapy.

- VII. Re-education—a planned program of teaching to stimulate and develop multiphase interests.

- VIII. Diversion.

Our facilities are planned to encourage the close association of patients undergoing physical restoration to permit the therapeutic effect of an improving patient on others.

Admissions are, therefore, limited to patients susceptible to significant improvement within 6 months. All patients must be referred by their physician.

Gaylord's newly remodeled Wheeler Pavilion was officially opened June 15, 1954 and makes available 18 beds to establish the program as a pilot plan. The Wheeler Pavilion is an entirely self-contained unit, designed to meet the vital needs of the program and will provide pleasant, semiprivate accommodations within the Sanatorium's grounds, but in facilities entirely separate from those used for tuberculosis care.

Inquiries should be addressed to Dr. Sterling B. Brinkley, Medical Superintendent, Gaylord Farm Sanatorium, Box 440, Wallingford, Connecticut.



Modern research and medicine's experience means better **HEALTH TODAY**.

This brochure tells the dramatic story of health progress—a 50 per cent reduction

in the general death rate, an increase of 21 years in life expectancy at birth and other important contributions made possible by medical advances.

This AMA publication and three others which contain useful health information are available in quantity, without charge. They may be used as mail enclosures, reception room information pieces and for community meetings.

The full series or individual leaflets may be obtained by filling out and mailing the order blank on this page.

Connecticut State Medical Society  
160 St. Ronan Street  
New Haven 11, Connecticut

Please send me without charge the following leaflets in quantities indicated:

- HEALTH TODAY (medical progress) ..... copies
- ON GUARD (AMA evaluation of drugs) ..... copies
- "QUACK" (dangers of treatment by quackhealers) ..... copies
- WHY WAIT? (the role of the family physician) ..... copies

NAME.....

Office Address.....

.....



## FROM OUR EXCHANGES

Tenney discusses in the President's Page of the *Wisconsin Medical Journal* (53:1) the criticism that some of the Board members had granted an unlimited license to some osteopaths. He calls attention to the fact that the laws of Wisconsin permit osteopaths to take examinations for a full license and that this law was approved by the State Society.

Dr. Tenney continues to the effect that the law does not have the unqualified approval of all the physicians of the State. Nevertheless it is the law of the State of Wisconsin. Attention is called in the editorial to the fact that there are many indications that the education given in osteopathic schools "is rapidly approaching that given in medical schools; and that as soon as the osteopathic schools will submit to the same evaluation now required of medical schools, the way will be cleared for a substantial increase in the number of physicians qualified to treat the sick."

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There appears in the *Wisconsin Medical Journal* of January, 1954 (53:1) an informative discussion of "Medical Partnerships." Physicians who are thinking of forming a partnership would do well to safeguard their future by a careful study of this discussion. It is an important decision which necessarily includes intimate relations at professional, financial and personal levels. It is the part of wisdom to employ a competent attorney who is familiar with the ethical and the other considerations which should be carried over into a medical partnership. It is believed prudent, in terms of tax saving and of time savings, to have partnership books established and periodically audited by a certified public accountant.

\* \* \* \*

There is both experimental and clinical evidence that two antibiotics used simultaneously may be more efficient (synergistic) or less efficient (antagonistic) in their action than either drug used alone.

Elek, Hilson and Jewell present a simple method suitable for routine diagnostic work (*Brit. Med. Jour.*, 4849). It reveals interactions of the bacterial effect of antibiotics in vitro. Penicillin with either

chloramphenicol or aureomycin generally showed antagonism. Streptomycin with chloramphenicol was synergistic.

\* \* \* \*

"The Clinical Evaluation of Gitalin in the Treatment of Congestive Heart Failure" as presented by Dimitroff et al. tends to support the belief of many investigators that it is superior to other digitalis glycosides (*Ann. Int. Med.*, 39:6). Their report is based on the treatment of 68 patients suffering from congestive heart failure of varying causes, degrees and duration. Gitalin was safely, comfortably and effectively useful in initial digitalization, redigitalization and maintenance digitalization of patients in heart failure. In eight patients in whom digitalis, digitoxin and Digoxin were ineffective due to toxicity, gitalin was of value in promptly and safely establishing digitalization and control of heart failure. No toxicity was encountered in any patient studied. The clinical application of the wide difference between toxic and therapeutic dose in gitalin is an important advance in the pharmacology of cardiac glycosides.

\* \* \* \*

"The Problems that Arise in the Use of the Intramedullary Fixation Principle in Fractures" can usually be divided into four groups (*Stack, Jour. Iowa State Med. Soc.*, XLIV:1).

1. There are those that arise from poor choice. There is an attempt to use the method in a type of fracture for which it was not designed.

2. There are difficulties that arise from faulty technique, such as the improper choice of nail, or no preoperative choice at all, improper position on the table, insufficient help during the operation, difficulties with the knees or buttocks because of a nail that is too long, malpositions which have been mentioned previously, and impalement of the nail in the region of the isthmus so that it cannot be driven through and cannot be extracted, and the instruments broken in the attempt at extraction.

3. Certain complications may occur during the healing period, such as bending or breaking of the nail due to premature weight bearing, external rota-

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Edward Gipstein, M.D. announces the opening of a diagnostic laboratory and electrocardiographic reading service at 181 Broad Street, New London.



# ANNUAL REPORTS

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

### 1953 - 1954

(Concluded)

#### REPORT OF THE COMMITTEE ON MENTAL HEALTH

Franklin S. DuBois, *Chairman*

Francis J. Braceland  
John H. Bumstead  
Charles W. Culotta  
Clifford D. Moore

John H. Foster  
Foster E. Priddy  
G. Gardiner Russell  
Henry Sherwood

During the past year the efforts of the Committee on Mental Health have been directed primarily toward two objectives; establishment of a central administration of the State's mental health system and formulation of a program designed to bring inpatient psychiatric services to general hospitals.

It is gratifying to record, even though it is long since public knowledge, that the first objective has been achieved. The 1953 General Assembly enacted into law a measure which established a Department of Mental Health that has been functioning since October 1, 1953. The Department consists of a Council of Mental Health (composed of representatives of the State Mental Hospitals and the Child Study and Treatment Home and appointees of the Governor) and the office of Commissioner of Mental Health, a position to which Governor Lodge has recently appointed Dr. John Blasko. Your Committee is confident that expedition of service to the mentally ill and economy to the State will, in time, amply justify the vigorous support of this legislation by the Society, its officers and its Committee on Mental Health.

The task of bringing inpatient psychiatric services to general hospitals has progressed more slowly because of the complex medical, administrative and economic problems involved. Nevertheless, your Committee can report definite steps forward. It has cooperated with the State Hospital Association, the State Department of Health and the State Services in the formation of a Joint Committee for the furtherance of the project. This Joint Committee, composed of representatives of the several organizations—including Dr. Moore from the Committee on Mental Health—is now active under the chairmanship of Dr. Albert Snoke.

The Committee has continued to study other problems in the area of mental health: the work and relationship of clinical psychologists to psychiatrists (Dr. Bumstead, Dr. Russell and Dr. Sherwood); commitment procedures (Dr. Braceland); the care of mentally deficient and mentally disturbed children (Dr. Culotta); mental health facilities in the schools (Dr. Foster); and outpatient psychiatric clinics (Dr. Priddy). Reports on these studies together with recommendations will be made at a later date.

Respectfully submitted,  
Franklin S. DuBois

#### REPORT OF THE CONNECTICUT COMMITTEE FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION

William G. H. Dobbs, *Chairman*

Harold A. Bergendahl  
James C. Canniff  
Morris A. Hankin

Harry C. Knight  
John O'L. Nolan  
James H. Root, Jr.

Alfred J. Sette

At a national meeting of the Foundation in January 1953, it was reported that a number of state and county associations were planning to conduct their campaigns through personal contact by campaign teams of physicians in their own communities.

After exploring the potentials of this type of campaign, the committee decided that, although much more planning and organization would be required, such a campaign would have the advantage of better acquainting physicians with the problems of medical schools and increasing participation in the AMEF program.

A proposed plan for the campaign was then developed and was approved at a meeting of the Public Relations Committee on March 3, 1953.

The plan called for development of the campaign in three phases, with appropriate letters of procedure, information kits and organizational aids as follows:

*First Phase:* For County Public Relations Chairmen.

Required organization of county into campaign districts and appointment of volunteer leaders for each district. Direct contact with district leaders was initiated by the Society's Public Relations Section as soon as notification of appointments was received.

*Second Phase:* For District Leaders.

Required appointment of team members to conduct the campaign in each district, based on an average of ten to fifteen physicians to be personally contacted by each team member. Specially designed contribution cards, imprinted with names and addresses of physicians, and postpaid return envelopes, were furnished district leaders for distribution to team members to facilitate subscription and forwarding of contributions.

*Third Phase:* For Team Members.

Required personal contact of physicians listed on contribution cards supplied by district leaders. Procedure letter explained ways in which physicians could contribute to medical school needs. The kit for this phase contained a quantity of factual information useful in answering questions that might arise.

In addition to the above operational phases, the campaign was promoted in the following ways:

1. A direct mailing to physicians early in December to encourage those who had not already done so to contribute before the end of the year.
2. Full page appeals in seven issues of the *Connecticut State Medical Journal*.
3. Presentations at annual and semi-annual meetings of county medical associations.
4. Field meetings in several counties to assist in completing the campaign.
5. Distribution of AMEF Handbook on Medical Education.

While the Public Relations Committee has guided policy and procedures of the campaign, its administration, including preparation of all the written and published material, has been carried out by James G. Burch, Public Relations Director. He has been assisted by Miss Barbara Juliano, a member of the secretarial staff, who has competently maintained the necessary accounting records and otherwise assisted in administrative functions.

More than 150 members of the Society, ranging from members of the Public Relations Committee to district leaders and team members helped to conduct the 1953 campaign.

The campaign brought total contributions of \$8,498 from 425 physicians, with an additional amount to be credited for contributions made directly to the medical schools and which have not yet been tabulated.

Through the courtesy of Mr. Chase Mellen, Jr., Executive Vice-President of the National Fund for Medical Education, the committee has been informed that 19 Connecticut corporations contributed \$52,570 to assist the medical schools during 1953.

At the close of the 1953 campaign, a complete report of its operational phases, accompanied by a portfolio of the materials used, was prepared by the State Office in two copies as permanent records for state and national headquarters.

In a letter from Mr. Hiram W. Jones, executive secretary of the American Medical Education Foundation, interest in obtaining additional copies of the report was expressed as follows:

"Many, many thanks for your full report, which is one of the very finest presentations I have ever seen. In fact, I like it so much that I should like to send a copy to each of our state chairmen.

"Therefore—and this is an urgent request—would it be possible for you to make up and send us 53 copies each of the materials that you have included in this presentation? We would then send a packet of these materials to each of our state chairmen, showing them what one state has done for the American Medical Education Foundation.

"Naturally, the AMEF will pay all costs for these materials. Please advise me as soon as possible if this request is feasible."

The copies of the report requested in the above letter were subsequently prepared and forwarded to the AMEF Chicago office.

The committee also has been assured that Connecticut will again be listed on the Honor Roll of States in the AMEF report for 1953.

Plans for the 1954 Connecticut AMEF Campaign are now nearing completion, with the prospect that the first appeals for contributions will be mailed during the month of May. Already a number of unsolicited contributions have been received and notable among them are substantial amounts given by the county chapters of the Woman's Auxiliary. This early and gratuitous response by the Auxiliary represents a significant contribution to the needs of medical education and is deeply appreciated.

The committee again records its appreciation for the generous response of an increasing number of physicians during each annual campaign and invites continued support for the campaign during 1954.

Respectfully submitted,  
William G. H. Dobbs

## REPORT OF THE CANCER COORDINATING COMMITTEE

Allan J. Ryan, *Chairman*

Matthew H. Griswold	Benjamin R. Reiter
Ralph E. Kendall	Francis A. Sutherland
William Mendelsohn	Ashley W. Oughterson
Edward J. Ottenheimer	Louis G. Simon

There were five regular meetings of the committee which were well attended. The business contracted during the year included the following items.

### 1. Medical Advisory Committee.

Doctors, Ottenheimer, Wells, Ogden, Evans, Taffel, Glazier and Barker were reappointed. The death of Dr. Wells created a vacancy in the committee which was filled by Dr. Kendall.

### 2. Professional Education.

This committee has again cooperated with the Association of Tumor Clinics to sponsor another State Cancer Conference for the medical profession. This was held in New Haven on March 10, under the direction of Dr. Morrison.

The new sound film "Oral Cancer" was reviewed and the committee recommends it without reservation to all doctors and medical staffs.

The committee has continued to subsidize various forms of educational cancer literature which are being sent to the doctors in Connecticut.

### 3. Cancer Detection.

The lists of doctors for the Cancer Detection Program is now out of date and needs immediate revision. Originally, it was hoped that the county medical societies would make their own revisions. It now appears that this committee will have to make this revision and suitable material will be sent to all doctors. The cooperation of all our doctors will be needed to make this revision possible.

### 4. Lung Cancer Project.

This committee is taking an active part in the program for early detection of cancer of the lung. Mass lung X-ray studies are to be undertaken and over a period of years this type of investigation should yield important data.

Respectfully submitted,  
William Mendelsohn, Secretary



## REPORT OF THE COMMITTEE ON THIRD PARTY PAYMENTS

Walter I. Russell, *Chairman*

Henry A. Archambault  
Donald G. Arnault

Lewis P. James  
Russell A. Keddy

This Committee has considered the topic of payments by Insurance Carriers including Connecticut Medical Service, Inc.

This problem has probably caused more controversy in the Council of the Connecticut State Medical Society than any other.

The conclusions arrived at by this Committee are:

(1) If a resident performs the service, such as an operation or delivery, he should personally bill the Insurance Carrier. This fee to be assigned to some fund, preferably educational, which shall be administered by the medical staff of the individual hospital.

(2) If an attending actually performs the procedure or service, he should bill the Insurance Carrier, the fee to be assigned to whatever purpose the medical staff of the hospital agrees. This concerns only "Ward" patients.

The decisions of this Committee are at variance with the ideas of the Council of the Connecticut State Medical Society and the Council and through its Secretary, has asked the Committee to suspend further consideration of the problem at this time.

Respectfully submitted,  
Walter I. Russell

## REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

Walter I. Russell, *Chairman*

Howard S. Colwell  
Daniel Hardenbergh  
Allan M. Ross

F. Erwin Tracy  
N. William Wawro  
Benjamin V. White

This committee meets with representatives of the Yale School of Medicine consisting of the following: Dean Vernon W. Lippard, Paul B. Beeson, Hugh L. Dwyer, Arthur Ebbert, Jr., and Albert W. Snoke.

The purpose of this Committee is to continue and strengthen the historic close relationship between the Connecticut State Medical Society and the Yale University School of Medicine and to further the effectiveness of the undergraduate and graduate programs of medical education.

Again, this year, the question of establishing a Student AMA Chapter at the Yale School of Medicine has been discussed. Previous efforts to establish a chapter were reviewed and it was decided that intensive efforts be employed to accomplish this end.

Discussion took place about The Yale-New Haven Medical Center arrangement as proposed. It will expedite teaching facilities for undergraduate and graduate students.

Plans for development of the minor specialties as dermatology and allergy are under way.

Plans for improvement of the post graduate courses given to physicians are underway. More practical and less pre-clinical subjects will be offered. Falling off in attendance

during the past year has been noted. This is probably due to better teaching programs now offered by the hospital.

Plans for the Clinical Congress in September were reviewed and an arrangement similar to last year's program will be used.

Respectfully submitted,  
Walter I. Russell

## REPORT OF THE BOARD OF DIRECTORS AND PROFESSIONAL POLICY COMMITTEE OF CONNECTICUT MEDICAL SERVICE

*Board of Directors—Connecticut Medical Service*

Henry A. Archambault  
Creighton Barker  
Thomas J. Danaher

Louis F. Middlebrook  
Thomas P. Murdock  
Walter I. Russell

*Professional Policy Committee of Connecticut Medical Service*

Henry A. Archambault  
Orpheus J. Bizzozero  
William H. Curley, Jr.  
Thomas J. Danaher

Thomas M. Feeney  
Louis F. Middlebrook  
Robert G. Reynolds  
Walter I. Russell

Edward J. Whalen

Copies of the Annual Report of CMS have been widely distributed so details of the operation of the plan, and the financial status will not be covered in this report.

1953 has been a year of crisis and far-reaching changes for CMS. In July we received notice from Connecticut Hospital Service, Inc., that it was invoking the ninety-day clause in our Agency Agreement, and as of October 21, 1953, would no longer carry out the functions of the agreement. The members of the House are well acquainted with the details of this separation as articles have been published in the *Physicians' Bulletin* and the *Connecticut State Medical Journal* and it has been discussed at the County Association Meetings—therefore, it is not necessary to review this subject in this report.

We were fortunate to obtain competent key personnel, and under the able administration of Dr. William H. Horton, we have efficiently taken over the entire operation of CMS at our new home office at 205 Whitney Avenue.

At the Annual Meeting in May, 1953, the House of Delegates approved a change in the CMS contract to the effect that diagnostic X-rays in physicians' offices on a ten dollar deductible basis would be covered and that there would also be a selective change in the fee schedule with a concomitant increase in the premium.

Due to the fact that CMS had to assume the duties that Connecticut Blue Cross had been carrying on for us, the Board of Directors of CMS postponed the revision of the contract that was intended to go into effect on January 1, 1954.

In spite of the numerous problems we had to face, further thought was given to the revision. It was finally decided that there should be, in addition to the X-ray coverage, a more comprehensive revision of the fee schedule with a larger increase in the premium and also an increase in the service benefit level.

The proposed revisions of the contract were presented to

the House of Delegates of the Connecticut State Medical Society at the meeting of December 9, 1953. At that meeting, one of the delegates (Dr. Nolan) stated, and I quote from the minutes, "I believe every single man who has signed up with CMS is entitled to look at this contract and see whether he wants it or not." Dr. Nolan then made this motion that was passed by the House, "That this whole problem be tabled and be referred to each individual physician that has a CMS contract and then report it back to the Annual Meeting."

In view of this action, the Professional Policy Committee of CMS decided that a referendum be conducted among the participating physicians. All the participating physicians have seen the results of the referendum which indicated an overwhelming support for the new contract. In view of the results of the referendum, and due to the fact that the timing of a new contract is fully as important as its contents, it was decided by CMS to go ahead and offer the revised contract. We now have approximately 125,000 members enrolled under this new contract.

Our present contract will continue to be in force and will be known as the Standard Contract; the revised contract will be known as the Preferred Contract. All subscribers of CMS will have the opportunity to continue under the Standard Contract or transfer to the Preferred Contract.

All participating physicians have received copies of the new contract and the new Physicians' Handbook; therefore, the details of the new contract will not be included in this report.

CMS, during the year, has successfully met the crisis of having to take over complete operation of the plan without injuring its services to either the subscriber or the physician. Also, it has been able to get into operation the Preferred Contract that will better serve both the people of Connecticut and the participating physicians. This has meant considerable activity by the persons who have the responsibility for administration but it could not have been accomplished without the interest and cooperation of two thousand participating physicians.

Respectfully submitted,  
Thomas J. Danaher

#### REPORT OF THE COMMITTEE REPRESENTING THE SOCIETY ON THE BOARD OF DIRECTORS OF CONNECTICUT HOSPITAL SERVICE

Edward J. Whalen, *Chairman*

This Society has had close relations with Connecticut Blue Cross ever since it was founded in 1937. In the developmental days, advice and counsel of the Society was freely sought. Later, at a time when Blue Cross needed substantial support before the public the By-Laws of the Corporation were amended to give the State Medical Society the privilege of naming three members of the Board of Directors, and this has been done for several years. Each year the Council named three members of the Society to serve as directors and contribute to the Board the kind of guidance that could come only from physicians. A member of the Society served as Secretary of the Corporation for three years.

Late in 1953 it became apparent that no good purpose would be served by having interlocking boards of directors of Connecticut Hospital Service and Connecticut Medical Service and Dr. Danaher and Dr. Barker, two of the Society's representatives on the Blue Cross Board, resigned from it. Dr. Edward Kirschbaum and Dr. Albert Snoke were named by the Council to fill the vacancies so created. The resignations of Dr. Danaher and Dr. Barker were not acknowledged by Blue Cross, nor were Dr. Kirschbaum and Dr. Snoke appointed to the Board. At about that time the Board of Directors of Blue Cross amended its By-Laws and cut the number of directors from thirty-one, to twelve and canceled the privilege of the Medical Society and the Hospital Association to make nominations. Soon thereafter I was notified that my membership on the Board had terminated.

Thus ends a long and useful association between this Society and Connecticut Hospital Service.

Respectfully submitted,  
Edward J. Whalen

#### REPORT OF THE JOINT CONFERENCE COMMITTEE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

Barnett Greenhouse, *Chairman*

Martin I. Hall	Fritz M. Meyer
Benjamin Katzin	Louis Soreff
Walter J. Keefe	William V. Wener

The Committee has been regular in its meetings, maintaining interest in its proceedings and activities and fostering friendly relations with the Connecticut Pharmaceutical Association.

Recently this Committee has been enlarged to include a representation from the Connecticut State Dental Association with the aim of maintaining professional relations among the three associations. This new departure is being looked upon with some interest and brings with it new possibilities for interprofessional relations.

The Sub-Committee on Foods, Drugs, Cosmetics and Devices is continuing its meritorious service to our state in its deliberations and evaluation of items brought to its attention in the above categories. Dr. Hugh Dwyer is the current chairman and Dr. Harry J. Fisher continues as its able secretary.

Respectfully submitted,  
Barnett Greenhouse

#### REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Thomas M. Feeney, *Chairman*

Morton Arnold	Hyman A. Levin
Barnett P. Freedman	Frank L. Polito
Winfield O. Kelley	Alfred Sundquist

At its semi-annual meeting on November 10, 1953, the Woman's Auxiliary to the State Medical Society fittingly observed its tenth anniversary. This happy occasion was celebrated in the presence of Mrs. Leo J. Schafer, President



of the Woman's Auxiliary to the American Medical Association. Your chairman was invited to this meeting and had the opportunity of bringing the greetings and thanks of the doctors of the state to the Woman's Auxiliary for their devoted efforts in our behalf.

Vigorous and resourceful women have devoted themselves to the interests of the doctors. Pleasant and close cooperation has been maintained during the past year between Mrs. Dewey Katz, President of the State Auxiliary and your chairman. Our efforts have been expended in exploring and advising ways and means whereby the working association between the two organizations will be most fruitful. Special effort has been made along these lines with regard to Civil Defense, Legislation and School Health.

Appreciation on our part for the hard work and dedication of the Auxiliary to the doctors' needs could be readily shown if each physician would subscribe to the worthwhile health information organ of the American Medical Association, namely, "Today Health." If doctors would subscribe to this magazine and prominently display it in their homes or waiting rooms, they would obtain some of the better public relations that the medical profession sorely needs today; furthermore, the Woman's Auxiliary would be assured that the doctors of the state are working effectively to promote one of the major objectives of the Woman's Auxiliary to the State Medical Society.

Respectfully submitted,  
Thomas M. Feeney

## REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

D. Olan Meeker, *Chairman*

Charles T. Schechtman	Frank H. Couch
Edward P. White	Joseph Fiorito
Thomas M. Feeney	Creighton Barker
Henry Merriman	

Chairman, Committee on State Legislation

The 83rd Congress convened January 3, 1953 and adjourned sine die August 3, 1953. During that period 10,695 legislative measures were introduced in the Senate and House. All of these were carefully screened by the Washington office of the American Medical Association and 274 were analyzed and reported. These bills were then studied by the Committee on Legislation of the AMA and in most cases approved or opposed by the Board of Trustees of the AMA. A few bills were too recent for review by the Board of Trustees.

It is gratifying to report again this year that several measures in Congress which received the approval and support of the AMA were enacted. No legislation completely opposed by the AMA was enacted.

There were 10 measures of interest to physicians enacted into law during the first half of the 83rd Congress. They are as follows:

1. Of 34 measures introduced on Veterans' legislation only one became law (HR5636). This lengthened the

presumption of service connection for all types of tuberculosis to 3 years following military service.

2. An investigation of the Veterans Administration by the House Veterans Affairs Committee (HR34). An appropriation of \$50,000 was voted.

3. Of 25 proposals dealing with military medicine, 10 were incorporated in the amended "Doctor-Draft" act. This act as amended was extended 2 years to July 1, 1955, including an extension of the \$100 a month equalization pay for physicians and dentists.

4. 14 bills were introduced to reorganize the executive department of the government; 5 became public law. One, HJR223, created the reorganization of the Federal Security Agency into the Department of Health, Education and Welfare and became Public Law 13 on April 1, 1953.

5. A new "Hoover" commission on re-organization of the executive branch of the government was created.

6. A Commission on Intergovernmental Relations became Public Law 109 on July 10, 1953.

7. Drugs and drug addiction were the subject of 10 bills. Six of these were concerned with factory inspection by agents of the federal food and drug administration. They became Public Law 217.

8. The Hill-Burton Hospital Construction Act was extended till 1957 as Public Law 151.

9. Senator Hunt in S1515 proposed to give authority to certain western states to form an interstate commission for jointly supporting higher education without federal financial participation. It could include medicine and dentistry. This became Public Law 226.

10. The appropriation ceiling was removed from the National Science Foundation under Public Law 223.

There were two major set-backs during the second half of the 83rd Congress. One was the defeat of the so-called "Bricker Amendment" by one vote. The reason Senator Bricker's name is used is that he was first on the list of 64 Senators who collectively proposed the amendment. Unfortunately, our two Senators, Prescott Bush and William Purtell voted against the adoption of this amendment. Both of them were original proposers. In the past they have voted for some treaty control legislation thus indicating their belief in some form of an amendment.

Actually, both of these men can be held responsible of thwarting the desire of the majority of their constituents.

This is neither the time nor place to discuss the many facets of the Bricker Amendment. There has been a great deal of what Senator Bush has seen fit to call "debate by epithet"—an attempt to appeal to the emotions instead of reason. Suffice it to say here that the United States was the first (1787) instance of any government declaring that treaties are to be the supreme law of the land. With a few minor exceptions all other governments have not followed our example. It is not a requirement of international law that treaties be enforced as municipal law in the courts of the contracting parties.

Secondly, the difficulty in distinguishing a treaty from an executive agreement and the uncertainty in stating what executive agreements require Congressional approval, make it hard to lay down a different set of rules for executive

agreements. The Yalta and the Potsdam Agreements are illustrative of executive agreements not ratified by Congress.

As most of you know, the great danger in our present wide open position regarding treaties or executive agreements is that our *internal* laws can be controlled by other nations or groups such as the International Labor Organization and the United Nations. At the risk of being redundant it would seem wise to include here the full text of the "Bricker Amendment" for your study.

(As approved by the Judiciary Committee of the U. S. Senate.)

A bill proposing an amendment to the Constitution of the United States relating to the legal effect of certain treaties and executive agreements.

Section 1. A provision of a treaty which conflicts with this Constitution shall not be of any force or effect.

Section 2. A treaty shall become effective as internal law in the United States only through legislation which would be valid in the absence of treaty.

Section 3. Congress shall have power to regulate all executive and other agreements with any foreign power or international organization. All such agreements shall be subject to the limitations imposed on treaties by this article.

Section 4. The Congress shall have power to enforce this article by appropriate legislation.

Section 5. This article shall be inoperative unless it shall have been ratified as an amendment to the Constitution by the legislature of three-fourths of the several States within seven years from the date of its submission.

As you can see, it is short, sweet, and to the point. A President who has no intention of deceiving Congress or the Nation by executive agreements should not object to legal restrictions which might prevent others from doing what he honorably would not do.

Fortunately, on March 2nd Senator Lennon (D. N.C.) moved to reconsider the vote which defeated the Bricker Amendment on February 27. As a result the resolution is now restored to the Senate calendar and can be called up for another vote at any time.

The second major set-back to physicians is that from all information available (February 26, 1954) the Jenkins-Keogh plan will not be in the Omnibus Tax Bill when reported.

So much for what has passed. Now what as to the future.

On February 13, 1954, a Regional Legislative Conference was held in New York City by the Committee on Legislation, AMA. The Chairman was Dr. David B. Allman who is Chairman of the Committee on Legislation, AMA. The purposes of the conference were (a) to explain and perfect the system used by the Committee on Legislation in alerting key legislative personnel in situations requiring immediate contacts with members of the Congress, and (b) to discuss the most important medical issues to be considered during the Second Session of the 83rd Congress.

Under (a) there was not much discussion. The plan offered consists of 1. a key contact M.D. for each state, 2. a key contact M.D. for each Congressional District, 3. a key contact M.D. for each County and finally, 4. local key contact people in each area. It was stated that an

alternate in each of the first three categories is a "must." That plan seems to put quite a few "keys" on the ring. Sometimes, with a ring-full of "keys" it is hard to pick out the right one to open the front door, especially in the dark when fumbling might occur.

In Connecticut we have anticipated this scheme to some extent and have one or more representatives of the Society in each Congressional District who are personal friends of the Senators or Congressmen.

It is not too difficult to contact these various key men when action is imperative. *The big rub is to know what the doctors of Connecticut want so we may advise our Legislators.*

As Delegates of the State Society you have surely read the article by Dr. Creighton Barker in last month's *Journal* on the results of our survey concerning Social Security and the Jenkins-Keogh Bill. If you happened to miss the article it will be refreshing for you to learn that the survey gave us no information of value. We, the House of Delegates of the Connecticut State Medical Society, are supposed to know what our local and county societies want regarding various national legislation. We are supposed to instruct our Delegates to the AMA House of Delegates how to vote. It is obvious that no such procedure occurs. Actually, the House of Delegates of AMA must usually decide its stand on various bills without any expression of opinion "back home."

A survey of possible ways of disseminating information and securing "grass-roots" opinions is now under consideration. One of the criticisms heard at the Regional Legislative Conference was that the Board of Trustees of the AMA does not represent the true feeling of the entire medical profession. Various surveys or local ballots were mentioned as being opposite to the decisions of the Board of Trustees.

The answer to that criticism is that the Board of Trustees is dependent on the House of Delegates and its decisions. The individual Delegates supposedly have been directed by their own State Society as to the wishes of the physicians in the state. You have seen, however, that even an attempt to get information from the individual doctor does not always give pertinent results. Our own survey on Social Security and the Jenkins-Keogh bill was a fiasco.

The underlying fault is that the average physician is so busy with his practice, family and civic affairs that he does not take the time to study the national legislative picture. Keeping up with the national medical political caravan is a tedious, continuing job. Hence, it soon devolves on a small group who either are interested or are compelled to become interested because of an appointment and a conscience. If any of you have helpful suggestions as to how we can get decisions of the local or county levels please advise us.

In closing I wish to thank those members of the Committee who attended the New York Conference and the entire Committee for their prompt response to the last minute alerting on both the Bricker Amendment and the Jenkins-Keogh Bill. Also to Creighton Barker, my sincere thanks for supervising the survey and his continual helpful suggestions.

Respectfully submitted,  
D. Olan Mecker



## REPORT OF THE COMMITTEE ON STATE BLOOD BANK

Ralph E. Kendall, *Chairman*

Irving B. Akerson	Lincoln Opper
Gerald J. Carroll	Charles H. Peckham
Joseph O. Collins	Karl T. Phillips
Frederick B. Hartman	Victor G. H. Wallace
Louis P. Hastings	Levin L. Waters
Christie E. McLeod	Ira V. Hiscock

June 12, 1954 will mark the fourth anniversary of the initiation of the Connecticut Regional Blood Program. During this period of operation over a quarter of a million pints of whole blood have been collected, processed and distributed to the hospitals of the state. Great credit is due to the 41 Red Cross Chapters whose combined efforts largely on a volunteer basis have made the recruitment of donors possible for this magnificent program. Almost an additional 100,000 pints have been collected for the Army and Navy for defense purposes and for gamma globulin preparation. In spite of these unanticipated demands on the Program, the Chapters have been able to meet the requests of your Committee for civilian use and each year they have attained the over-all quota that has been requested of them. There is continuously on hand throughout the state approximately a 14 day supply of whole blood which could be made immediately available in case of disaster. This is on the basis of 12 pints of blood per year per hospital average daily census. The use of blood has more than doubled in the state during this four year period. It does appear that a leveling off at this high plateau is taking place.

Frequent meetings of the Committee have concerned themselves primarily with the problems of misuse of blood and to this end have recommended the establishment of hospital auditing committees made up of the Blood Bank Chairman and staff members. This program was outlined at a special meeting of the Committee with the Blood Bank Chairmen of the various hospitals.

The year has seen the establishment of a supply of fresh frozen plasma for the use of the hemophiliac residents of the state. The Hemophiliac Association has been active in providing us donors and facilities at the Center for maintaining this emergency supply.

The recurring problem of providing continuous and new donors is being more closely integrated by a recently established Liaison Committee made up of members of the Red Cross, Connecticut Hospital Association and members appointed by the Blood Bank Committee.

While blood expanders of various kinds continue to appear, there has been no satisfactory substitute so far developed for whole blood transfusion. Relatively safe blood plasma and serum albumin is now available as a by-product of the transfusion program.

The constant and continuing need for donor recruitment is of paramount importance and the efforts of the Red Cross should be actively supported by all members of our Society.

Respectfully submitted,  
Ralph E. Kendall

## REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, *Chairman*

Enos J. O'Connell	William H. Upson
James H. Inkster	Gaert S. Gudernatch
Frederick A. Beardsley	William H. Pomeroy

The Committee on Rural Medical Service had its greatest success this year with the exhibits at the State Fairs. In this work we were greatly aided by the work of the Woman's Auxiliary to the State Medical Society and for this we are grateful. We also wish to gratefully acknowledge the help given by Mr. James Burch. It is our opinion that such work has great public relations value, and for this reason we intend to continue it.

The Committee feels an interest in the undoubted fact that more and more people appear to be leaving cities and going into rural areas. It is our feeling that this may in time dislocate the balance of medical care in the State.

Lay people are becoming more and more interested in good health. It is becoming more and more common for various groups to council together in an effort to improve the health and medical care in a community. It is our sincere hope that the local doctor will give his utmost co-operation to any such effort. Nothing can take the place of good sound medical guidance.

Respectfully submitted,  
Norman H. Gardner

## REPORT OF THE DELEGATES TO THE COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

William H. Horton	Cole B. Gibson
Creighton Barker	

Your delegate was present at the two meetings of the Council of the New England State Medical Societies which were held in Boston since the last annual meeting.

The meetings were well attended and many topics were discussed which were of mutual interest to physicians in the New England area. Some of the more important matters considered were: the desirability and feasibility of establishing regional medical, dental and veterinary facilities to provide increased training opportunities in those professions for the youth of the New England area; a detailed study of the extent of the practice of osteopathic healing in the New England states, and physicians placement programs.

At the November meeting a resolution was passed as a memorial to Doctor Howard who had been President and a leading figure in the Council of the New England State Medical Societies. Doctor Creighton Barker served as an alternate to Doctor Howard at the November meeting and ably presented the notable steps which the Connecticut State Medical Society has made in physician placement as well as the relatively satisfactory situation which exists in Connecticut regarding osteopathic practice.

It seems apparent that the Council of the New England State Medical Societies offers a forum for discussion of important medical matters of mutual interest to New England physicians that thus far has been utilized only to a minimal degree.

Respectfully submitted,  
William H. Horton

## REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Chairman

Egbert M. Andrews	Norton Canfield
Joseph J. Bruno	Joseph N. D'Esopo
George A. Buckhout	Benjamin M. Shenker

Excellent cooperation between physicians and the Veterans Administration in the Connecticut Home-Town Medical Care Program for Veterans has been evident throughout the year.

No grievances were brought before the committee, either by physicians, representatives of the Veterans Administrations, or individual veterans.

The number of physicians enrolled in the program increased to 1500 during the year, as compared to approximately 1350 physicians last year. This represents a more than three-fold expansion of physician participation since the plan was initiated in 1946 with approximately 400 physicians enrolled at that time.

Our veteran population also has grown and is now estimated at approximately 310,000, an appreciable increase over the 275,000 veterans residing in Connecticut following World War II.

During the fiscal year July 1, 1952, through June 30, 1953, 14,508 Connecticut veterans received treatment for service-connected disabilities by physicians participating in the program. Total treatments number 29,437, at a cost of \$148,877. An average of 1209 individuals were treated per month. They received an average of 2.453 treatments each month at an average monthly cost of \$12.406.

Meetings of the committee were held on four occasions to coordinate procedures and to negotiate the contractual arrangements with the Veterans Administration under which the program operates.

Officers of the Hartford Regional VA Office, Colonel Harry T. Wood, Manager; Dr. Francis J. Ryan, Chief Medical Officer, and William H. Feery, Medical Administration Officer, have spent considerable time assisting the committee in administrative matters and this has been most helpful.

Members of the committee attended two conferences with officers of the State Medical Society and the American Legion. These conferences were held to explore the aspects of proposals to curtail VA hospital care for veterans whose disabilities are not connected with their military service. A resolution embodying such a proposal was adopted by the American Medical Association's House of Delegates at its annual meeting in New York last June.

Three conferences sponsored by the American Medical Association on this same subject also were attended by

committee members. The first of these was a national conference of state committee chairmen in Chicago, September 1, 1953. This was followed by two regional conferences, for committee members and medical association officers, one in New York on November 13, 1953, the other in Boston on March 28, 1954.

There has been sufficient publicity concerning this subject in recent months to make it quite obvious that sharp disagreements exist.

Officers of the American Legion contend that adoption of the AMA proposal would wreck the present system of medical care for veterans because veteran hospitals would lose a large number of general medical and surgical cases in the non-service-connected category, with consequent impairment of residency training programs. This would bring about a decline in the organization and competence of VA medical staffs, it is contended, thus adversely affecting the care of veterans with service-connected disabilities.

Representatives of the American Medical Association's Committee on Federal Medical Services have declared that the stand adopted by the AMA House of Delegates does not mean depriving veterans of adequate care, but envisions the expansion of local hospital and medical facilities which would also provide better care for other community residents. It is acknowledged that any such transfer of responsibility must evolve gradually because of the time that would be required to plan and develop additional local facilities.

These are only two of the specific differences of opinion that surround this intricate subject. Your committee has studied the available statistics, survey reports and other material, but feels further study is necessary. Therefore, no recommendation is made at this time.

Information concerning many aspects of the issue has recently been made available in a handbook published by the American Medical Association and copies may be obtained at the office of the State Medical Society. As additional material is made available, this information program will be expanded.

A variety of interpretations have been noted concerning the action taken by the AMA House of Delegates and it may therefore be pertinent to restate its essential terms.

The action constituted adoption of a recommendation contained in the report of the Reference Committee on Insurance and Medical Service and originally embodied in a report of the Special Committee on Federal Medical Services, as follows:

"Your committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

(a) Veterans with peacetime or wartime service whose disability or diseases are service-incurred or aggravated; and

(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expenses of necessary hospitalization.



Your committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining group of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs.

The recommendation of the Committee with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of non-service origin in federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the committee, however, that the entire question of whether the care of these patients is a local or a federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administration for the benefit of all. Preferential treatment for veterans with these non-service-connected disabilities cannot be continued indefinitely, in view of its detrimental effect on the health and the economy of the entire nation."

The committee extends since appreciation to all participating physicians for their active cooperation in the Connecticut program.

Respectfully submitted,  
Samuel B. Rentsch

## REPORT OF THE COMMITTEE ON THE CARE OF THE CHRONICALLY ILL

Martin Heinemann, Chairman

Richard I. Barstow	James S. Missett
Sidney Drobnes	Michael S. Shea
Chester W. Fairlie, Jr.	Harold E. Speight
Alexander J. Tutles	

The organization, coordination and expansion of facilities available in our State for the care of the chronically ill is promoted by various agencies under the chairmanship of individuals with specialized qualifications.

Our Committee would like to participate in the solution of these technical and legislative problems as required but to concern itself primarily with professional and educational needs.

Regular meetings of the committee members about every two months were planned. It was decided, as a beginning, to collect data regarding the most common cause for chronic disability in the aged: Cerebral Vascular Accidents. Such information obtained from various institutions should permit comparisons and, it is hoped, initiate a program of activities best suited to the background and interests of the members of this committee.

We are fortunate to have available the very competent and most generously given experience of Doctor Sidney Shindell, Medical Director of the Commission for the Chronically Ill, Aged and Infirm.

Respectfully submitted,  
Martin Heinemann

## REPORT OF THE COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Carl E. Johnson, *Chairman*

Eric H. Blank	A. Rocke Robertson
Bernard F. Mann, Jr.	W. Leslie Smith
Norman C. Margolius	Hoyt C. Taylor
Hugh K. Miller	Archibald W. Thomson, Jr.
Charles H. Peckham	Stanley B. Weld
Elizabeth C. Wells	

The Committee to Study Maternal Mortality and Morbidity of the Connecticut State Medical Society held 5 regular meetings during 1953, all of which were well attended.

The committee held one joint meeting in January, 1953, with the Committee on Neonatal Mortality of the Connecticut State Medical Society. At this meeting it was decided that neonatal mortality cases in which there are obstetrical factors involved in the outcome of the case should be referred to the Committee to Study Maternal Mortality and Morbidity. There was a total of 10 neonatal mortality cases reviewed by the Committee to Study Maternal Mortality and Morbidity during the year 1953.

One open session was held in the Farnam Amphitheater at Yale University School of Medicine on November 17, 1953, at which time 2 cases of maternal mortality were presented for discussion to Yale Medical students. The session was well attended, and there was thoughtful discussion on the part of the students.

In the May, 1953, *Connecticut State Medical Journal* (page 429), the committee published a list of normal and major obstetrical procedures. This list was prepared with the hope of providing assistance to hospitals of the state that were interested in setting up a standard for obstetrical procedures for which consultation should be required. The list is the composite result of suggestions received from the various obstetrical departments established and operating in the general hospitals in Connecticut.

The work of this committee since its inception has been primarily concerned with the review of maternal mortality cases and the introduction of methods which might reduce the maternal mortality rate. This year with the maternal mortality rate 0.2 per thousand live births, the committee recognized that it is now time for the committee to comply with its full title and to begin a study of maternal morbidity. It was the decision of the committee that toxemia morbidity should be studied first since toxemia is the leading cause of maternal death and more knowledge of toxemia should help in reducing the number of deaths due to toxemia. Because the problem was recognized to be of considerable magnitude a subcommittee on toxemia was appointed with Hugh K. Miller, M.D., chairman. The subcommittee had its first meeting on June 10, 1953. The work of this committee began with the review of cases of maternal mortality due to toxemia which had been referred to the subcommittee on toxemia by the Committee to Study Maternal Mortality and Morbidity. A meeting was held in October, November, and December. At the December 9, 1953 meeting selected cases of toxemia morbidity were discussed and a form was prepared to be sent with a covering letter to all maternity hospitals in the state with the request that this

form be completed for each case of toxemia complicating pregnancy and that the form should be returned to the Bureau of Maternal and Child Hygiene of the Connecticut State Department of Health. From this form it is hoped that more will be learned about the incidence of toxemia in Connecticut. A number of the cases reported will be reviewed by the subcommittee on toxemia. From information which has been gathered from other individuals in other states, this is the first attempt that has been made by any state to study maternal morbidity.

The program for making fibrinogen available to hospitals has been continued and the supply of fibrinogen available to Connecticut hospitals has been increased. Toward the end of 1953 through the Cutter Laboratories fibrinogen has been made available commercially.

The committee has long recognized the need of the assistance of a pathologist on this committee. This year Bernard F. Mann, Jr., M.D., Pathologist, has been appointed as a member of the committee.

The committee realizes a great loss in the death of Joseph Howard, M.D., whose work as chairman of the committee in its early years laid the foundation for the present high level of obstetrical care given to Connecticut patients.

Respectfully submitted,  
Carl E. Johnson

## REPORT OF THE STUDENT MEMBERSHIP COMMITTEE

Morris P. Pitock, *Chairman*

William F. Bauer, Jr.	William H. Lohman
William E. Bloomer	Allan K. Poole
Nathaniel Kenigsberg	Arthur C. Unsworth
John B. Wells	

Executive Secretary of Society

Your committee on Student Membership has been completely inactive since its last report to you because circumstances were unfavorable in the matter of any activity at Yale Medical School.

Since the change of administration at the Medical School, it was thought that the new Dean would be more cooperative in an approach to the students. However, the opportunity for such an approach presented itself only at this late date. On Tuesday evening, March 16, 1954, Mr. Russell Staudacher, of the Student American Medical Association SAMA arrived from Chicago to address such students as would be sufficiently interested in SAMA activities to appear at a 5 P. M. meeting. Your Chairman and Dr. Nathaniel Kenigsberg, a member of your committee were present at this meeting. Dean Vernon Lippard and Assistant Dean Thomas R. Forbes were also present.

Mr. Staudacher presented a film of the 1953 SAMA convention held in Chicago. He spoke of the aims and hopes and prospects of further growth of SAMA, stating that there were now sixty-seven active chapters at Medical Schools throughout the country.

The situation at Yale Medical School remains clouded as regards the status of its chapter. Although it is carried

as a charter member by SAMA the students themselves do not consider that they are charter members, although nearly 70 of the students receive the journal SAMA and pay the annual \$1.00 dues.

The fact that only six students appeared at this meeting though a notice of the meeting had been placed in each of their mailboxes for a week before, is mute testimony of the inertia which we are attempting to overcome.

It is the opinion of your committee chairman that Dean Lippard made every possible effort to arouse the interest of the student body in SAMA activities. He was present at the meeting, addressed those present in a manner which I consider entirely praiseworthy.

Respectfully submitted,  
Morris P. Pitock

## REPORT OF THE COMMITTEE ON EMERGENCY MEDICAL SERVICE

Benjamin B. Whitcomb, *Chairman*

Orpheus J. Bizzozero	C. Fredrick Yeager
Alfred L. Burgdorf	James C. Hart
Joseph J. Esposito	Mrs. Helen Cullen, R.N.
Ralph W. Kendall	Mr. Hiram Sibley
William B. Smith	Frederic S. Harold, D.D.S.
	Mr. Felix Blanc

The Committee on Emergency Medical Service has had two formal meetings. 1. The first one was held on June 24 in conjunction with the officers of the various county medical societies and officers of the State Department of Civil Defense. The responsibilities of the physicians in Civil Defense were outlined at this meeting and initial plans made for statewide organization and recruitment of physicians for Civil Defense posts in the event of disaster.

2. Various members of your Committee spoke at the meetings of the county medical societies to acquaint the members with these responsibilities and methods of recruitment to fulfill them.

3. The second formal meeting was held on December 3 which was a progress meeting. It was reported here that each county, with the exception of New Haven County, had agreed to some method of recruitment and assignment of physicians which was to be done through the professional staffs of the various hospitals, the assignments to be done in collaboration with the area medical directors. Dr. Prout, the medical director of the State Department of Civil Defense, has been in attendance at most of these meetings which has greatly facilitated the liaison between the State Department of Civil Defense and the Connecticut State Medical Society.

It is hoped that during the next few months, each physician in the state will be apprised of the duties he is requested to perform in the event of a disaster, and it is hoped that he may become better informed in some of the particulars of the type of casualties likely to occur and their treatment with the equipment and material available through the Civil Defense Agencies.

Respectfully submitted,  
Benjamin Bradford Whitcomb



## REPORT OF THE CONFERENCE COMMITTEE WITH THE CONNECTICUT STATE DENTAL ASSOCIATION

Edward T. Wakeman, *Chairman*

David J. Cohen  
Cornelius S. Conklin

Camille H. Huvelle  
Brae Rafferty

The purpose of this committee is to be a continuous conference group with representatives of the State Dental Association and to provide an opportunity for the discussion of problems of mutual interest to the two professions and to bring these professions into closer relationship in scientific fields and the field of social and public welfare.

Since the last report there have been three meetings of this committee. On June 9, 1953 the committee considered the subject "What Place Should Dentistry have in Medical Education." Doctors Bert Anderson, Wilbur Johnston and Vernon Lippard were participants.

Discussion brought out in some detail the organization and purpose of the Departments of Dentistry at Harvard, Columbia, Rochester, and Yale, and their influence on scientific dental research. At Yale the medical students gets a fair exposure to the principles and practice of good dentistry; a better exposure perhaps than in any other school in this country. This is brought about by integrating with formal courses in basic sciences and related medical disciplines without providing a formal course in dental science.

Emphasis was placed on the importance of scientific research. Dentistry is a highly specialized aspect of medicine. There is a need for more dentists with a medical background and medical men with an interest in dental research. The value of team-work is apparent.

On October 13 the committee considered methods for handling complaints from the public against doctors and dentists. Invited guests were Dr. William McMahon, Chairman of the Committee on Professional Relations of the Connecticut State Medical Society, Dr. John Booth, President of the Medical Examining Board, Mr. Luke Stapleton, Counsel for the Connecticut State Dental Society, and Dr. Creighton Barker.

Dr. Barker opened the discussion with an interesting account of the historical background of Boards of Censors. The idea of Medicine policing its own behavior is not new.

Dr. McMahon indicated that the State Committee on Professional Relations is composed of eight members, one from each county. Public complaint against a doctor can be made to the County Board of Censors or to the Commissioner of Health. The County Board of Censors acts as a Court of original jurisdiction. The complainant is treated with kindness and given a chance to talk. If the case cannot be settled here to the satisfaction of the complainant it is referred to the Committee on Professional Relations. The complainant is required to appear in person before this committee. If not satisfied, the case may then be referred to the Council. Public complaint can also be made directly to the Commissioner of Health and referred by him to the Medical Examining Board.

The Medical Examining Board consists of five members appointed by the Governor on recommendation of the

House of Delegates. It serves two functions, the examination of candidates for licensure and the hearing of charges against physicians when brought by the State Department of Health. In discussing the latter, Dr. Booth expressed the wish that the doctor could be protected from unfavorable publicity.

Dr. Arnold and Mr. Stapleton outlined the procedure of handling complaints against dentists.

On December 15, the committee considered the operation of the Governor's Commission on a Regional Dental, Medical, and Veterinary School. Discussion was led by Mr. Robert Alcorn, Chairman of the Commission. Dr. Henry T. Quinn represented the dental group and Dr. Creighton Barker represented the medical group.

Mr. Alcorn expressed in principle that Connecticut has an obligation to its men and women to provide the opportunity for training in Medicine, Dentistry, and Veterinary Medicine. Since Connecticut has no state institution to provide such training, our men and women have to seek admission to schools outside of Connecticut. Due to local demands it becomes more and more difficult for other states to accept students from out-of-state. Is there sufficient demand to justify establishment of a state medical, dental and veterinary school which would be very costly, or would it not be better to form a compact with one or more institutions outside of Connecticut to accept students from Connecticut, and have this state share expense on a per capita basis?

Dr. Quinn stated that the dentist per population ratio was adequate in Connecticut. About fifty dentists move into this state each year.

Dr. Barker pointed out that there was no real need for physicians anywhere in New England with the possible exception of Maine. He also stated that applications to all schools is declining. The proportion of medical school applicants accepted in 1953 was exactly the same as in 1929.

Since this meeting was largely informative, no conclusions were drawn. A public hearing will be held in 1954.

Respectfully submitted,

E. T. Wakeman

## REPORT OF THE COMMITTEE TO STUDY NEONATAL MORTALITY

John W. Buckley, *Chairman*

William K. Bannister  
Ronald Beckett  
Joseph A. Fiorito  
Louis Guss  
Charles A. Murphy

Albert U. Peacock  
Charles H. Peckham  
Jessie E. Parkinson (Representative of the State Health Department)

This committee functioned this year as a separate committee. It had been formerly a subgroup of the Public Health Committee.

During the year we were saddened by the loss of one of our members, Dr. Gilbert Hubert. Dr. Hubert had been a valued member of the committee since its inception.

In this review of neonatal mortality, the need for the

advice and suggestions of a pathologist and an anesthesiologist became apparent. For this reason, Dr. Ronald Beckett and Dr. David Little were added to the committee. Dr. Little was later recalled to active duty in the navy, and Dr. William Bannister was appointed in his place.

Our major work of the year has been the evaluation of the neonatal deaths selected on a statistical basis by the State Health Department. Too few cases have been received to form any major conclusions as to correctible measures to employ in the reduction of neonatal mortality in Connecticut. It is planned to publish in the *Journal* of the Connecticut State Medical Society a statistical survey of the results of our studies during the next year.

As our work continues, we are made constantly aware of the important role the Connecticut State Health Department plays in the maintenance of high standards in our hospital nurseries.

Respectfully submitted,  
John W. Buckley

## REPORT OF THE CONFERENCE COMMITTEE WITH THE STATE BAR ASSOCIATION

George H. Gildersleeve, *Chairman*

H. M. Marvin  
Andrew J. Jackson

Sidney Shindell  
Creighton Barker

This is a new committee appointed by the Council on June 26, 1953, and replaces the Committee on Expert Medical Testimony. The first meeting was held with a similar conference committee from the State Bar Association in New Haven, November 5, 1953. The purpose of this meeting was to become acquainted, to develop an organization between the two groups, and to bring up topics for future discussion. Mr. J. W. Holloway, Director of the Bureau of Legal Medicine, American Medical Association, and Mr. Edwin J. Holman, a member of Mr. Holloway's staff were present as guests and discussed the advantages and objectives of the conference committees.

A second meeting was held in New Haven January 7, 1954, and was well attended by representatives from both groups. Expert medical testimony was discussed.

A great deal of enthusiasm has been shown by both conference committees. The outcome of these meetings can be very fruitful and can do much to correct medicolegal faults in Connecticut.

Respectfully submitted,  
George H. Gildersleeve

## REPORT OF THE CONFERENCE COMMITTEE WITH THE AMERICAN LEGION

George H. Gildersleeve, *Chairman*

Stanley B. Weld  
Samuel B. Rentsch

Egbert M. Andrews  
Norton Canfield

The Conference Committee with the American Legion has held two joint meetings with a committee from the American Legion, Department of Connecticut.

The first joint conference was held June 20, 1953 at the Veterans Home and Hospital, Rocky Hill. This meeting was well attended by members of both committees as well as by representatives from the Connecticut State Dental Association, The Connecticut Hospital Association, and the Connecticut Rehabilitation Commission. Also present was Mr. John H. Burke, National Field Representative of the American Legion, and Dr. H. D. Shapiro, Senior Medical Consultant, National Rehabilitation Commission, Washington, D. C. The principal purpose of this meeting was to discuss the treatment of non-service-connected disabilities in Veterans Administration Hospitals and particularly the policy and feeling of the American Legion in relation thereto.

A second meeting was held January 18, 1954 at the offices of the Connecticut State Medical Society in New Haven. In addition to the members of the two committees this meeting was attended by members of the Connecticut State Medical Society's Committee on the Medical Care of Veterans, and by Dr. Irving B. Brick of Washington, D. C., and Mr. John Burke representing the American Legion.

Dr. Russell B. Roth of Erie, Penn., a member of the Committee on Federal Medical Services of the American Medical Association, and Mr. C. Joseph Stetler, legal counsel and Secretary of the AMA Committee on Federal Medical Services, were present as guests of the Connecticut State Medical Society. The purpose of this meeting was to discuss the handling of nonservice-connected disabilities in Veterans Administration Hospitals and the American Medical Association policy in relation to the treatment of these disabilities. This viewpoint was ably presented by Dr. Roth and Mr. Stetler.

These conference meetings have been interesting but highly controversial. There seems to be little likelihood of any agreement between the two conference committees on this debatable issue where such a difference of opinion exists.

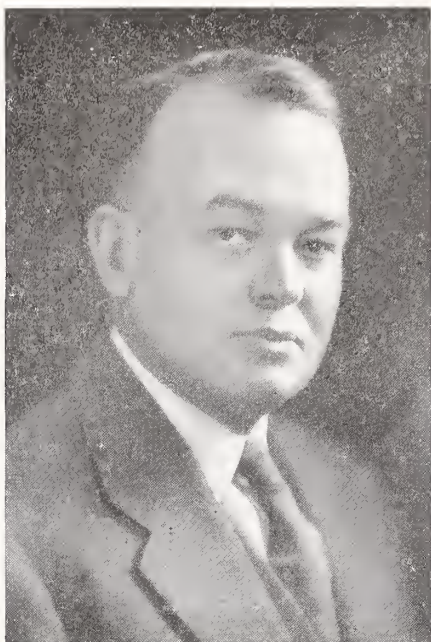
Respectfully submitted,  
George H. Gildersleeve



## OBITUARIES

### Donald Breckenridge Wells, M.D.

1884 - 1953



Dr. Donald Wells, visiting surgeon of the Hartford Hospital, died in Hartford, December 22, 1953 of carcinoma of the kidney.

To the members of the Connecticut State Medical Society, Dr. Wells' name was invariably associated with the management of the burned patient. This lifelong interest in burns made him a recognized authority in this field. Among his early contributions was a paper entitled "Treatment of Electric Burns by Immediate Resection and Skin Graft." It is to the great credit of Dr. Wells that he was the first to condemn the tannic acid treatment of burns, a method he himself had pioneered and championed for many years. Later he turned his efforts to the treatment of burn shock and Connecticut owes a debt to his vision and determined efforts toward a statewide blood bank. It is doubtful if the Connecticut Regional Blood Program would be active now if it were not for his foresight and driving energy.

Forcefully forthright in praise and criticism he was at the same time kind, gentle, intensely loyal and fair. His unfailing sense of duty and organizing capacity is well shown in the carefully worked out

plans for war catastrophes which operated with remarkable effectiveness at the time of the circus fire tragedy. Throughout his life he was extremely active and productive in postgraduate education of himself, of his associates and of his hospital.

Born in Hartford July 23, 1884, he attended public schools, Yale University, and received his M.D. degree from Johns Hopkins Medical School in 1912. For three years he was house surgeon at St. Luke's Hospital, New York City, and on July 1, 1916 was appointed to the surgical staff of the Hartford Hospital. He became a visiting surgeon and served as president of the Medical and Surgical Staff. In World War I he was with the Yale Mobile Hospital, Base Hospital 39, with rank of Captain, MC. A Diplomate of the American Board of Surgeons (Founders Group) he was consulting surgeon to many neighboring hospitals.

A member of numerous medical societies, he was particularly active in the Hartford Medical Society (president 1949), New England Surgical Society, and New England Cancer Society (president in 1942 and 1943).

He was a Fellow of the American Medical Association, American College of Surgeons, and New York Academy of Medicine.

The Society owes much to Donald Wells for his enthusiasm, his inspiration, his integrity and his warm friendship.

Ralph E. Kendall, M.D.

### THE LINK BETWEEN

(Written for Donald B. Wells, M.D.)

"It is your hand," I said, "the Surgeon's hand,  
That is the link between this earth and heaven—  
The hereafter seen so close until your hand,  
The surgeon's hand, proves surety of earth,  
And heaven fades away into the blue"—

You only smiled, and said no word in answer—

Yet pleased that knowledge came with patient truth,  
Which those intimate hours exact with skill.

This precious truth forever worn as gold  
Is laid upon experience now,

A filigree of truth, and hope and faith—

The understanding tenderness of hands,

The surgeon's hands that touched the hand of God.

Martha Linsley Spencer

**Robert Phineas Knapp, M.D.**  
1885 - 1954



Dr. Robert Phineas Knapp, who served as medical director at Cheney Brothers, died at Manchester Memorial Hospital on March 15, 1954.

Born in Saratoga Springs, New York, on April 28, 1885, Dr. Knapp was well known in the East in his field of industrial medicine. He attended Syracuse and Columbia Universities, receiving his medical degree from the latter in 1911. He then served his internship at Harlem, Bellevue and Allied Hospitals in New York City and in 1916 became assistant surgeon attendant at Harlem Hospital.

During World War I he served with the Armed Forces, going on active duty in May 1917 at Fort Porter, New York. He was stationed as captain with the Surgical Service Base Hospital No. 8 at Savenay, France until February, 1919.

In 1920 Dr. Knapp came to Cheney Brothers in Manchester as assistant medical director under the late Dr. C. C. Burlingame, and succeeded him as medical director in 1923. He held this position at the time of his death. While medical director of this firm he developed his department into one of the best in the State. He was frequently consulted on industrial medical subjects and was the author of several monographs. He was elected president of the Industrial Medical Association for 1937-1938. Dur-

ing his years at Cheney Brothers he took a very active part in Red Cross work in Manchester and for many years assumed the sole burden of instruction in Red Cross first-aid training.

He worked quietly and effectively, and made no effort to spare himself in his work with his patients; this self-sacrificing quality was a large factor in hastening the ravages of the diseases which finally overwhelmed him. His general characteristics and his buoyant cheerfulness made him a host of friends. He was respected and esteemed by those in his profession, and his loss will be keenly felt in the community where he lived and practiced. He belonged to the American Medical Association, the Connecticut State Medical Society, the Hartford County, Hartford, and Manchester Medical Societies. He was a member of the original surgical staff of Manchester Memorial Hospital.

Dr. Knapp is survived by his wife, the former Agnes Buchanan Maclaren of New York; two sons, Robert P. Knapp, Jr., a member of the law firm of Breed, Abbot and Morgan of New York City, and William R. Knapp, an associate editor of *Reporter Magazine*; and six grandchildren.

Amos E. Friend, M.D.

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**Dr. Martha Eliot Accepts Award**

Dr. Martha Eliot, member of the Connecticut State Medical Society and chief of the Children's Bureau of the U. S. Department of Health, Education and Welfare, accepted one of three awards presented by Lord & Taylor on May 3 at a luncheon at the Waldorf-Astoria in New York. These awards, each consisting of a scroll and \$1,000, were presented to the Children's Bureau, to the Kips-Bay Yorkville Adult Counseling Center and its research counterpart, Cornell Medical College's Studies in Gerontology, and to the Social Science Research Council for outstanding contributions in the field of helping human beings better to cope with the social demands of the times.

Dr. Eliot requested that, since the Bureau is unable to receive cash donations, the \$1,000 be assigned to the Katherine F. Lenroot Scholarship Fund. Presentations were made by Miss Dorothy Shaver, president of Lord & Taylor.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Newell W. Giles, Darien*

*President-Elect, Mrs. Norman J. Barker, Collinsville*

*First Vice-President, Mrs. J. ALFRED WILSON, Meriden*

*Second Vice-President, Mrs. Frank L. Polito, Torrington*

*Recording Secretary, Mrs. Charles Culotta, Hamden*

*Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob*

*Treasurer, Mrs. Joseph Woodward, New London*



MRS. NEWELL W. GILES

Mrs. Newell W. Giles, newly elected president of the Woman's Auxiliary to the Connecticut State Medical Society, held the first board meeting of the year in her home on Monday, June 1. At that time a list of instructions and suggestions was handed to the officers and committee chairmen which set forth the president's own ideals and conception of the Auxiliary's purposes. This list proposed that the State and county leaders know the Auxiliary, its aims, ideals, projects and functions; that they set the wheels of any project in motion; that they use initiative and leadership; that they be prompt in the discharge of duties; that they devote time and energy outside of regular committee meetings to completing projects.

#### School of Instruction

In line with the president's outline of Auxiliary policies a School of Instruction was held on June 7 in New Haven to acquaint officers and committee chairmen with the responsibilities of their positions. Mrs. F. Erwin Tracy addressed the group. Before describing the "family tree" of Auxiliary, national, State and county, she put before the group a collection of papers, magazines and pamphlets which

would thoroughly acquaint them with their work. These she designated the "tools" of leadership and they included the Handbook of the National Auxiliary; the *National Bulletin*; the AMA Washington Letters; the minutes and reports of National annual meetings; the *Connecticut Quarterly*; the CONNECTICUT STATE MEDICAL JOURNAL; the county, State and national constitutions; "The First Twelve Years," a history of National's beginnings; a history of the National Auxiliary written more formally than the earlier one; Robert's Rules of Order; McCall's Pocket Book of Parliamentary Pointers; It's Your AMA; and the *Journal of the AMA*.

She then offered an informative and interesting history of the National and State Auxiliaries. Their activities were based on a series of requests from the AMA to the groups of doctors' wives who had banded together to further their husbands' medical interests and to acquaint doctors' families with one another. The activities of the auxiliaries were:

1. To promote interest in *Hygeia (Today's Health)*;
2. To help alert both its members and the public to the hazards of some of the current medical legislation;
3. To promote health education and further health measures, especially as they concern children;
4. To create scholarship funds of various kinds;
5. To serve the country during war time;
6. To inaugurate a program of nurse recruitment;
7. To serve the local community, particularly in the field of rural health;
8. To aid in Civil Defense;
9. To raise money for the AMEF.

"Surely," said Mrs. Tracy, "there is some phase in so varied a program which would interest every physician's wife.

Round table discussions were followed by short summaries by one member of each group to outline

what the discussion had yielded. From the fullness of these reports it was evident that the members had truly received instruction and could enter their offices prepared for forceful leadership.

### State Meetings

On May 6 Mrs. Giles attended the Rhode Island Auxiliary annual meeting. On May 10 Mrs. Giles and Mrs. Dewey Katz were guests of the New York State Auxiliary at their State Convention.

### County News

#### FAIRFIELD

The annual meeting was held April 20 in Stamford. Guest speakers were Cecelia Mallon, supervisor of nursing for the United Fruit Co., who spoke on "Nursing in the Tropics;" Irma Bannister, student nurse at Norwalk Hospital, recipient of Fairfield County's 1953 nursing scholarship. She spoke on "Experiences of the First Year of Training;" attorney-at-law, Margaret Sigsway, who spoke on "Mechanics of Politics."

County officers are: President, Mrs. Edwin R. Connors; President-Elect, Mrs. Charles Sheard; Vice-President, Mrs. Robert Nespor; Recording Secretary, Mrs. R. G. Wiggans, Jr.; Corresponding Secretary, Mrs. Nicholas E. Creaturo; Treasurer, Mrs. Fritz Meyer.

#### HARTFORD

A Membership Tea was held May 25. Approximately 150 members attended. In order to make the board less cumbersome the music and art committees will have a cochairman under the program committee. Rural health and school health will each have a cochairman under the public relations committee, thus eliminating three committees.

The new officers are: President, Mrs. Robert Tennant; President-Elect, Mrs. Charles Sullivan; 1st Vice-President, Mrs. Nicholas A. Marinaro; 2nd Vice-President, Mrs. Gerald Greene; Recording Secretary, Mrs. George J. Rosenbaum; Corresponding Secretary, Mrs. William H. Horton; Treasurer, Mrs. Robert Osmond; Assistant Treasurer, Mrs. Joseph Russo.

#### LITCHFIELD

On April 24 a dance for the benefit of the AMEF realized about \$150. Thirty-five dollars from this amount was added to the \$50 already budgeted,

making a total of \$85 for Litchfield's contribution for the past auxiliary year.

The county has filled its *Today's Health* quota with 64 points.

Officers for 1954-55 are: President, Mrs. Daniel P. Samson; Vice-President, Mrs. Andrew Orlowski; Secretary, Mrs. Royal A. Myers; Treasurer, Mrs. I. S. Goldberg.

#### NEW LONDON

At the first board meeting plans were discussed for the Student Nurses Welfare and Scholarship Bridge and Cake Sale to be held in September. Mrs. Frederick Fagan will be chairman.

The new officers are: President, Mrs. Joseph J. Mahoney; President-Elect, Mrs. James Harkins; Treasurer, Mrs. David Rousseau; Treasurer-Elect, Mrs. Anthony Loiacono; Secretary, Mrs. Norman Rasmussen; Corresponding Secretary, Mrs. George Kennedy.

#### WINDHAM

Officers for the coming year are: President, Mrs. Angelo J. Gulino; President-Elect, Mrs. Winston Hainsworth; Secretary, Mrs. James Major; Treasurer, Mrs. Karl Phillips; Assistant Treasurer, Mrs. John Woodworth.

## NEWS

### *from County Associations*

#### Fairfield

Mr. Arnold P. Olson, executive secretary of the Fairfield County Medical Association, has established an office of the Association at 211 State Street in Bridgeport.

The regular monthly meeting of the Bridgeport Medical Association was held in the auditorium of Bridgeport Hospital on June 1. The speaker was Francis D. Moore, surgeon in chief at Peter Bent Brigham Hospital, Boston, and Moseley professor of surgery at Harvard Medical School. Dr. Moore presented an interesting paper on "Guiding the Daily Care of the Sick Surgical Patient."

Among those attending the wedding of John F. Nolan, president of the Bridgeport Medical Association, to Katherine S. Quinn of Bridgeport on June



7 in St. Patrick's Church, Bridgeport was the executive secretary of the Connecticut State Medical Society, Creighton Barker.

The Annual Golf Tournament of the Bridgeport Medical Association will be held at the Longshore Country Club in Westport on July 7. Edward F. Trautman is the chairman of the committee on arrangements.

Physicians at the three Bridgeport Hospitals are busily engaged in the campaign to raise funds for the building program of the hospitals.

## Hartford

William Lee Gills of West Hartford, retired eye, ear, nose and throat specialist and formerly chairman of the Department of Ophthalmology at the Hartford Hospital, died suddenly at his home on May 27 at the age of 68.

On June 11, 1954, the Hartford County Medical Association's executive offices moved to 242 Trumbull Street in the Standard Building. The office suite, containing 1,112 square feet is on the fourth floor overlooking the corner of Pratt and Trumbull Streets.

Lowell Thomas discussed Hartford County Medical Association's recent survey of physician's estates, "How to Die Like a Millionaire," on his May 10 broadcast. The survey was picked up nationally by International News Service and United Press.

Twenty-four hundred blotters announcing the emergency medical telephone services in New Britain and Hartford have been sent out to new residents in these areas in the last eighteen months by the executive office.

A new display by the Connecticut State Medical Society featuring 15 emergency medical plans throughout the State was on exhibition in the lobby of the Hartford Hospital for two weeks this month. The display will go on tour throughout Connecticut.

WKNB TV is now featuring five minute films, prepared by the AMA and sponsored by Hartford County Medical Association. These films cover such illnesses as sore throats, home accidents, cuts and bruises, etc. On the same station in April, Dr. Louis Spekter of the Connecticut State Department of Health, Miss Katherine Burns of the Hartford Health Department and Mrs. Charles E. Jacobson, Jr., appeared to explain the Salk polio vaccine.

A special committee for studying medical insurance plans, consisting of Drs. Benjamin V. White, chairman, Martin I. Hall, Alfred B. Sundquist, Roswell D. Johnson, Samuel Donner, and James S. Missett, met this month to discuss the basic principles involved in the dealings of nonsurgical practitioners with third parties.

The committee discussed some of the situations which occur in the nonsurgical field for which inadequate or no provision is made in existing contracts—such as the general practitioner who travels a long distance to deliver his patient to the hospital, or the physician with a patient requiring detailed supervision during or following a surgical procedure.

A study is now being made of seven Blue Shield plans and their experience with their plans.

Tentative approaches to a suitable medical plan both from the point of view of the public and the physicians were outlined in regard to cost structures.

Medical staff members of each of the county hospitals will receive from their representative on the committee a preliminary draft drawn up by the medical division of Hartford Hospital called, "Principles for nonsurgical Practitioners in Dealing with Purveyors of Third-Party Payments."

Dr. George A. F. Lundberg was reelected president of the Manchester Heart Association at a meeting of the Board of Directors in May.

Drs. Joseph C. Barry, Harold J. Lehmus, Howard J. Lockward and Jacob A. Segal are also directors of this organization.

Dr. Ralph J. Littwin, Bristol Hospital radiologist, spoke to the Bristol Rotary Club recently about certain aspects of the American Cancer Society program.

New president of the New England Dermatological Society is Dr. E. Myles Standish.

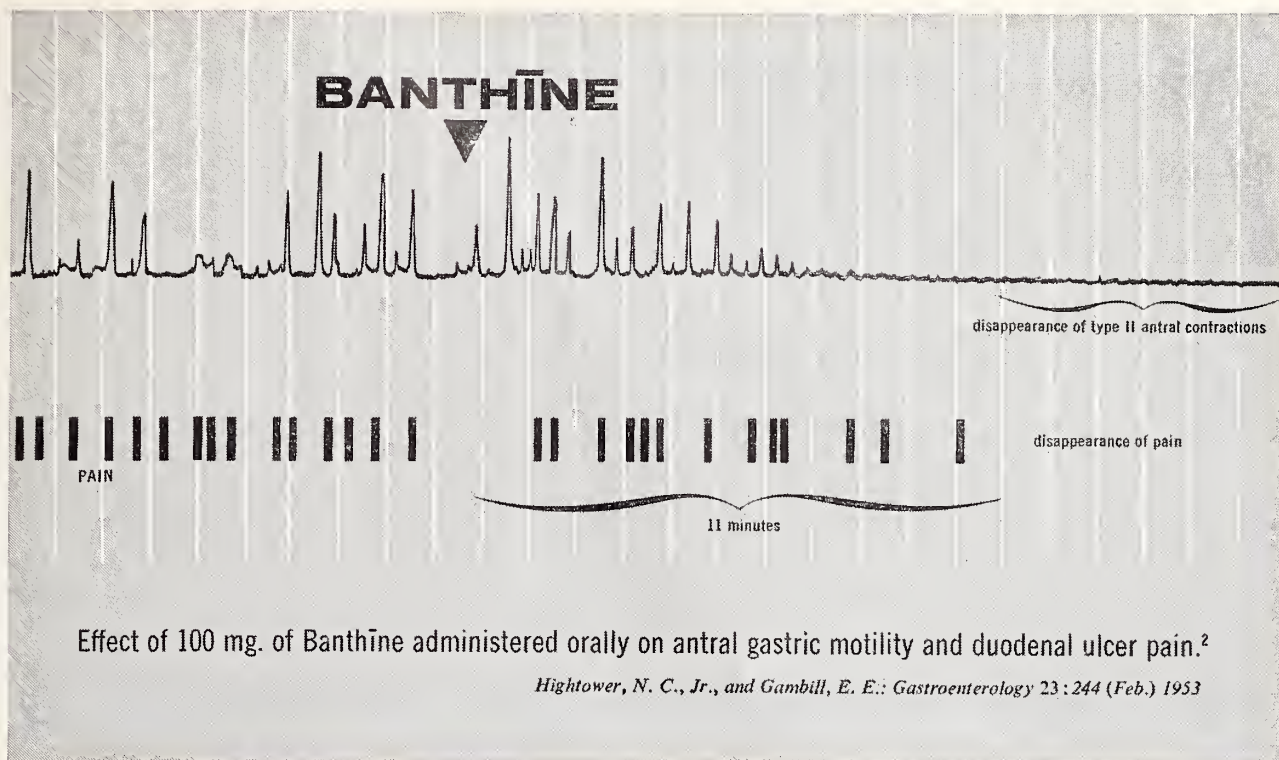
The Colonel Jeremiahs Wadsworth Branch of the Connecticut Society of the Sons of the American Revolution is now headed by Dr. H. Gildersleeve Jarvis. He was elected president in April.

The New Britain Lions Club recently elected Dr. Harold M. Clarke as their new president.

Dr. Frank O. Wood is now in Europe for an extended tour of cancer treatment centers.

A new transfer from New London is Dr. Bryce A. Smith, who is on the Tuberculosis Commission.

Speakers for last month were: Drs. Francis J. Braceland and John Donnelly of the Institute of



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Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: *J.A.M.A.* 153:1159 (Nov. 28) 1953.

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Living. Dr. Braceland was guest speaker for the annual Communion breakfast of St. Justin's Ladies Guild, and Dr. Donnelly talked to the Hartford Junior Chamber of Commerce.

Dr. J. Howard Johnston, director of the Bureau of Industrial Hygiene of the State Department of Health, participated in a panel discussion at the YMCA Industrial Council Foreman's Night in New Britain.

Dr. Winfield T. Moyer of Manchester spoke to a PTA group on children's diseases.

Dr. Ranald J. M. Steven, anesthesiologist at Hartford Hospital, spoke last month to the Women's Evening Group of the Asylum Avenue Baptist Church.

### Middlesex

Phil Schwartz is the co-author of an article, "The Cutaneous Manifestations of Systemic Diseases," which appeared in the *New England Journal of Medicine*, January 14, 1954 issue.

John Korab was recently elected president of the Middlesex chapter of the Connecticut Heart Association.

Harry Knight attended the annual meeting of the American Urological Association held in New York early in June.

### New London

The monthly dinner lecture meeting of the Lawrence and Memorial Hospital was held May 20. The speaker was Robert P. McCombs, senior physician, New England Center Hospital, and professor of graduate medicine, Tufts College Medical School. "Respiratory Function and Respiratory Failure" was the subject.

The Connecticut Heart Association held its monthly cardio-vascular lecture on Thursday, May 27 at the Lawrence and Memorial Hospital. Guest speaker was Benedict Harris, associate clinical professor of medicine at Yale and attending cardiologist at Grace New Haven Hospital. He spoke on "Experiences with Anti-coagulants."

The New London County Medical Association held its monthly meeting on June 3 at the Mohican Hotel. Langdon Parsons, professor of gynecology

at Boston University was the guest speaker. His topic was "Medical Endocrinology."

The regular monthly meeting of the William W. Backus Hospital was held on May 13. Ira Nathanson, associate professor in surgery, Harvard Medical School, spoke on "Problems In Cancer."

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## NEW BOOKS IN REVIEW

**SEXUAL BEHAVIOR IN THE HUMAN FEMALE.** By the staff of the Institute for Sex Research, Indiana University; Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, Paul H. Gebhard, and others. Philadelphia-London: Saunders. 1953. 842 pp. \$8.

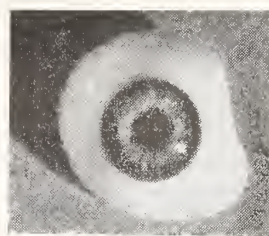
Reviewed by CHARLES W. STEPHENSON

Certainly no book has yet been released with the review coverage that this book has received. To add another review would seem to be some sort of hyperbole indeed. After all, not many books are given the dignity (or, perhaps, indignity) of reviews in such extremely diverse magazines and journals as *Esquire* and *Science News Letter*, the *Woman's Home Companion* and *Science*, *Colliers* and the *American Journal of Psychiatry*, just to mention a few. Actually some gave not one but two issues to reviews of this book, as the *Companion* and *Cosmopolitan*, as well as *Red Book*. Of course many of these were for the lay reader, but the contents were in most instances which I came across about the same. The emphasis varies a bit depending upon the bias of the reviewer, but the data are Kinsey & Co.'s.

Perhaps one of the very best of the reviews which summarized the contents was that which appeared in *Life* on August 24, last, at the time when the Great Release took place. For those who do not wish to spend the interminable hours of boredom reading the book, I would recommend the *Life* digest. If one wishes to achieve distinction with the exact figures it is, of course, then necessary to study the book itself.

Much contention has arisen in various circles regarding what is said to be Kinsey's intent to establish a new sexual mores for the people of this country. It seems to me that those who make this contention have neglected to read with entire open mindedness the very warnings which Kinsey puts into the text in various places. I have been impressed with the degree of emotional tension with which some of the reviewers who purported to be the most "scientific" have attacked not only the data presented, the statistical manipulations (all fully explained either in this volume or in its predecessor), but the man himself. It is interesting to note in this connection that so far as I have been able to find, all reviewers consider only the opinions of Kinsey; his co-workers are relegated to the limbo.

That finding of this Indiana group which has seemed to astonish the greatest number the most, is that of determining that in the group which these researchers interviewed, the time necessary for the female to achieve orgasm, when, indeed she is going to do so, is not significantly longer than the time required by the male. But that the female is much more easily distracted from the aim of sexual gratification is made manifest. And what husband doesn't already recognize this? How common is it for the wife to protest the fondling approach when she has her mind on other matters? To the male, the dishes, sewing, or other domesticities, should never be permitted to interfere with the "business of life," while



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to the female, the amorous moment should never be permitted to interfere with the routine of living the daily chores.

I would never wish to be in the position of upholding Dr. Kinsey and his workers in all their conclusions. I believe that they may have been misled at times. I am sure that what they have to say about the electroencephalogram taken during orgasm is completely erroneous, and that the sample given as illustrative of certain typical EEG patterns is a beautiful sample of nothing but movement artifact with scarcely one wave which can be identified as coming from the cortex. Too bad that this was not subjected to more critical review prior to publication.

But I cannot agree with those who wish to impute to the Kinsey group a complete "phantasy," as Hobbs and Kephart seem to wish to do in the February *American Journal of Psychiatry*. Why not, rather, admit that while the authors themselves acknowledge the imperfections of their sample, and the shortcomings of their data in certain areas the book does fill a great gap in the world's knowledge. One need not necessarily agree with them on their choice of statistical method, but they have carefully and fully explained their methods, so that none need be taken unaware. I believe that they have tried to be eminently fair, and themselves have pointed out every "defect" which has been poured out in the several and sundry reviews.

There is a great wealth of material contained in the book, but it is certainly boring reading; there is too much repeti-



tion, too much rehandling of the same data from different points of view, to make the perusal an interesting and stimulating one. It is more like a good reference work, but one which might well never be read in its entirety, as I, in my punctilious way, did.

**ILLUSTRATED REVIEW OF FRACTURE TREATMENT.** By Frederick Lee Liebolt. Los Altos, California: Lange Medical Publications. 1954. \$4.

Reviewed by JAMES H. P. GARNETT

This book is a 229 page paper-bound outline designed to illustrate and to discuss briefly the diagnosis and treatment of fractures for the medical student, the house officer, and the general practitioner. In preface, the author classifies his book as a supplement to standard orthopedic texts and denies any attempt at completeness.

The first three chapters consider anatomy and physiology, clinical examination of fractures, and general principles of treatment of fractures, all squeezed into sixteen pages. The remaining fourteen chapters are organized by anatomical regions and deal with specific fractures strictly outlined under etiology, incidence, pathology, clinical findings, x-ray, treatment, complications, time of immobilization and healing, and prognosis. The volume is profusely illustrated with drawings and diagrams and some x-rays. A great deal of space is devoted to sketches illustrating mechanism of injury. No mention is made of strain, sprain, or dislocation.

Fracture treatment is an extremely controversial subject when reduced to the specific, and the concise outline form of Dr. Liebolt's book produces some very questionable assertions, which would doubtless be qualified and modified were space to permit. A few such excerpted statements are listed below:

- (1) Intramedullary nails should be reserved for cases of nonunion.
- (2) Nondisplaced fractures of the pelvis should be immobilized for eight weeks.
- (3) Fractures of the lower end of the radius should be immobilized for 8-10 weeks.
- (4) Fractures of the surgical neck of the humerus, even with proper reduction, rarely achieve a good functional result because full motion of the shoulder joint is seldom attained.
- (5) Simple fractures of the ribs should be treated by

placing adhesive completely around the chest and tightening during expiration.

(6) Fractures of the spine should be placed in hyperextension plaster jackets for 6 months.

(7) In physical therapy treatment of fractures passive motion should precede active and must be undertaken early.

(8) Fractures of the metacarpals should be immobilized by a plaster cast extending from the elbow to the tip of the fingers.

Few practicing orthopedists would agree with the above statements. Other criticisms are: too many cartoon-like sketches, too few x-rays, far too little material on basic principles of fracture treatment.

As a text this book is unreadable by reason of its outline form; as a reference it is dangerously inadequate; as a review it is misleading; and as a supplement it fails to supplement.

**THE JEALOUS CHILD.** By Edward Podolsky, M.D., Department of Psychiatry, King's County Hospital, Brooklyn, New York. *Philosophical Library.* 1954. 142 pp. \$2.50.

Reviewed by LOUIS H. GOLD

This small book is rather unusual in that it attempts to confine itself to the study of the jealous child. Actually there is considerable description of child psychology and the title should have been broader. There are twenty-five chapters but some are only four to five pages long. Unfortunately this has a tendency to chop up the content. A few of the titles are "The Child As A Functional Unit," "What Causes Jealousy," "How The Child Reacts To His Physical Defects," "The Special Problems Of The Maladjusted Child," and "The Unwanted Child." The book gains interest as one proceeds and the last several chapters contain much valuable material, particularly in discussing the child's relationship with his parents and with other people.

The general theme of this book deals with the pattern of behavior of the handicapped child and his interpersonal relations. It is practical and sensible. There is frequent reference to psychodynamics and there are many excellent points of view which will prove useful to parents, teachers, social workers, nurses, pediatricians and the family physician. This volume is therefore recommended as a useful contribution in the field of child psychology.



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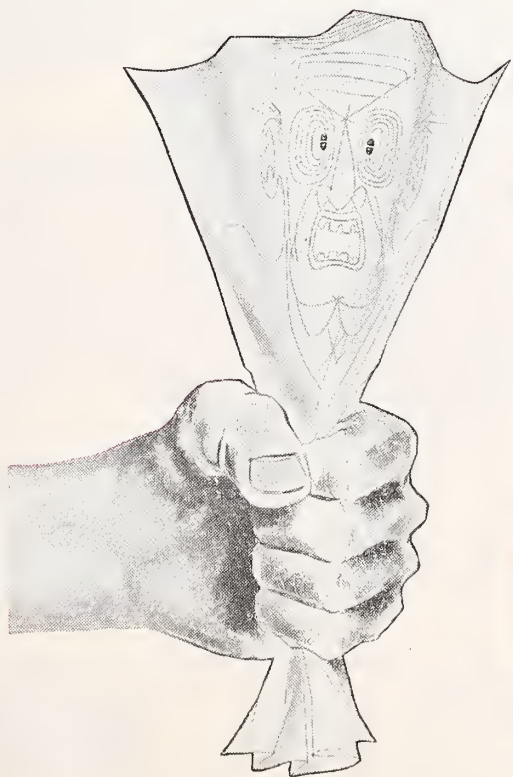
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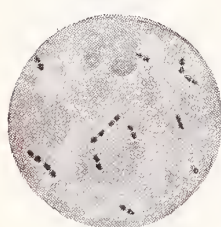
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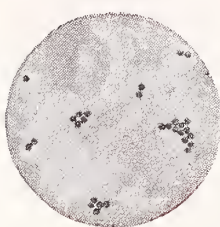
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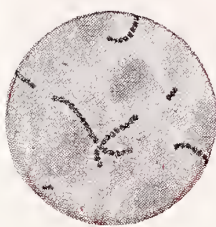
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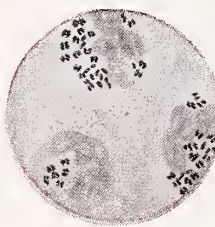
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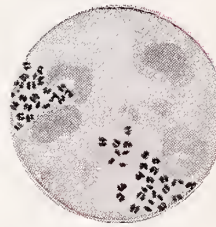
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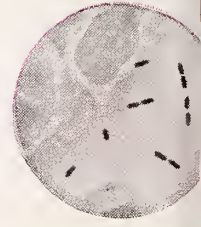
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# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVIII

AUGUST, 1954

No. 8

## THE PAPANICOLAOU TECHNIQUE

### Its Value in the Diagnosis of Pulmonary Cancer

N. CHANDLER FOOT, M.D., *New York City*

#### INTRODUCTORY

Pulmonary cancer is definitely and steadily on the increase, its upswing of incidence becoming more and more pronounced as time goes on. As the most noticeable increase has occurred during the past decade one searches for causes that might have increased in number proportionately to this steep gradient. Cigarette smoking, oil-combustion apparatus of various sorts, tarring of roads and like factors are under investigation. I cannot discuss them in the time allotted me, but an outline of the procedure for diagnosing the presence of pulmonary cancer by cytologic examination of sputum and of bronchial aspirations or washings can be reasonably well presented. There is nothing very new and little of a complicated nature involved in the preparation of smears and their diagnosis; the diagnostician should be a pathologist who knows his cancer cells when he sees them and he should have a good technician to prepare well stained smears. As experience in making cytologic as opposed to histologic diagnoses is necessary, it naturally follows that it would not be feasible for the average general practitioner of medicine or surgery to attempt to carry out his own cytology, but he can prepare smears for examination in the laboratory.

#### INDICATIONS FOR RESORTING TO CYTOLOGY

Any patient with an intractable, spasmodic cough, particularly one that produces blood-streaked sputum, should have a cytologic examination of that sputum. Chain cigarette smokers and patients with "asthma" should be particularly suspect, especially if they are fifty years old, or thereabout. The hack-

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The Author. *Professor Emeritus Surgical Pathology, Cornell University Medical College, New York, N. Y.*

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#### SUMMARY

Cytologic diagnosis should be made by pathologists but the smears can be prepared by the average general practitioner of medicine and surgery. Intractable, spasmodic cough, particularly if blood streaked sputum results, calls for a cytologic examination. This will afford a positive diagnosis of bronchogenic cancer before it can be discovered by a biopsy and is, therefore, a prerequisite to surgery.

Methods of collecting material for diagnosis and of preparing smears are outlined. The detailed procedure followed in the examination of the stained smears is given. Pulmonary cancer may be as readily detected by exfoliative cytology as may carcinoma of the female organs, i.e., in about 90 per cent of positive cases with the type accurately diagnosed in about 80 per cent.

ing cough of the cigarette smoker is a notorious red herring, as it misleads the physician into believing that it results from the irritation of the smoke rather than from the possible consequences of that irritation; the patient who thinks he has "asthma" has not always been under medical care and the diagnosis is his, rather than that of a medical man. Bronchogenic carcinoma can be detected in cytologic smears before biopsies to reveal its presence are possible. Often the bronchoscopist will not visualize a deeply-seated carcinoma situated beyond the range of his instru-

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mental vision. But a catheter introduced beyond this range into a suggestively reddened and inflamed bronchus may often produce exfoliated cancer cells that are unmistakable. There are now several cases on record in which carcinoma in situ, an incipient and noninvasive form of cancer, has been detected.

In one such case the tumor was scarcely visible to the naked eye, it was missed on gross examination of the removed lung but a recheck of the bronchial tree in the specimen finally revealed a small, elevated streak in a main stem bronchus that, on microscopic examination, presented a well developed carcinoma in situ. In spite of the smallness of this lesion, the sputum and aspirates had been regularly loaded with cancerous cells. I know of at least three or four such cases. If the surgeon wishes to attack cancer in its incipiency, here is his great opportunity. Unfortunately, most pulmonary cancers are well under way and already infiltrating when they are diagnosed in smears. Even so, with a possibility of pneumonectomy there is still a chance to remove the growth in the affected lung before it has metastasized to the lymphatics.

For these reasons, exfoliative cytologic examination is a "must" in the surgery of pulmonary cancer. It is eminently simple and practical and furthermore extremely reliable. Collecting the material often necessitates no pain or exertion on the part of the patient other than that occasioned by a deep cough and expectoration. It is only when the sputum is negative and the symptoms continue that the more troublesome ordeal of bronchoscopy must be applied—and the patient would probably have to have it, bronchial aspiration or no bronchial aspiration, anyway.

#### COLLECTION OF MATERIAL

The simplest material to be dealt with and the most readily obtained is sputum; this is procured by asking the patient to cough deeply and to expectorate the resulting sputum directly into a bottle containing some 30 cc. of 70 per cent alcohol. A shallow cough is no better than clearing the throat, as that is what it essentially is.

Bronchial aspiration or washing need only be resorted to if the sputum has been negative in spite of persistent symptoms, or if the question as to which lung is involved can not be settled by physical examination or the use of the x-ray. Should bronchial procedure be necessary, the supposedly involved bronchus should be aspirated through a catheter and

the aspirate evacuated into 70 per cent alcohol, or smeared directly on a microscope slide. It often becomes necessary to wash out the involved branch of the bronchial tree with three or four cc. of normal saline or Ringer's solution, which is mixed with equal parts of 80 per cent alcohol after it has been aspirated, and then it is centrifugated. This naturally requires the experienced service of a bronchoscopist and it is desirable that there be close cooperation between him and the cytologist; good teamwork is all important.

Sputum will present exfoliated cells from the respiratory tract as a whole (including the larynx) and cells are exfoliated from the oral cavity as well. Occasionally esophageal carcinomas erode into the trachea and exfoliate cells into the sputum. Bronchial aspirates will show fewer oral cells and inflammatory elements and more ciliated bronchial epithelial cells which are scraped off the trachea and bronchi by the bronchoscope.

#### PREPARATION OF SMEARS

The material collected should be smeared out evenly over glass microscope slides after it has been coagulated by the alcohol, or (in the case of bronchial sediments) centrifugated for some time. The smears are immediately plunged into equal parts of ether and 95 per cent alcohol which fixes them and renders them transparent, as it dehydrates at the same time. They are then stained by one of the Papanicolaou techniques, preferably one containing orange-G, which is invaluable in the detection of epidermoid carcinoma. It is best to have the stains carried out in a laboratory that is equipped to do such work. If the smears must be submitted unstained, they should never be permitted to dry out before fixation in alcohol and ether, otherwise the resulting distortion will cause false evidence of metaplasia. Papanicolaou prefers to have smears submitted in the fixative, which is possible when the laboratory is near at hand, but ether-alcohol is too inflammable to be entrusted to the mails, so that the fixed slides may be permitted to dry and be shipped in a dry state, or they may be coated with a little glycerol and covered by plain clean slides. After the smears are stained they are mounted under glass coverslips in a neutral mounting medium and are then ready for examination and evaluation.

#### EXAMINATION OF STAINED SMEARS

The cytologist, or an assistant, examines the smears under low magnification, the specimen being

searched from corner to corner of the coverslip in a mechanical stage. Any suggestively abnormal cells are marked by ink dots just above the field that contains them. This can be done by a trained technician and is known as "screening" the smear. The cytologist examines the marked fields and draws his conclusions. Should the cells and their nuclei be of unequal size and shape, with abnormally dense chromatin and large or numerous nucleoli; or should they be very irregularly outlined and bizarre in appearance, then the chances are that they represent malignant elements. One cannot apply any single criterion to the diagnosis; it is a matter of noting several abnormal features and applying the sum of them.

If there be many abnormal cells of this sort and the cytologist is sure that the evidence of cancer is conclusive, the smear is graded "class V," if he is not entirely convinced it is "class IV" (which is to be interpreted as "good evidence of cancer"). If there are some suggestive cells, the presence of which cannot be explained on the basis of inflammation but which do not bear all the earmarks of malignant change, the rating will be "class III." Negative smears are graded "class I" or "class II" according to whether there are any metaplastic changes in epithelial cells, but the difference is tenuous. Some cytologists prefer to grade smears as "positive," "doubtful," and "negative." Five consecutive positive diagnoses should indicate that even in the absence of positive biopsy operation should be seriously contemplated. Bronchoscopy will usually determine which lung is affected, the x-ray often confirming the evidence. It should be understood, on the other hand, that a negative report does not indicate that cancer is not present. All it means is that no cancerous cells were found.

#### ACCURACY OF CYTOLOGIC DIAGNOSIS

So far as accuracy is concerned, the diagnosis of pulmonary cancer through exfoliative cytology is practically on a par with that of malignant disease of the female genital tract; these two applications of the method head the list, with that of gastric carcinoma pushing up rapidly. A smear containing cancer cells is usually readily recognized by an experienced man, the cells stand out prominently in contrast to other elements and they are often clustered into characteristic clumps. Indeed, one always

feels safer if such groupings are present. There is little danger of confusing the malignant cells with leukocytes, histiocytes (most of them containing dust), or exfoliated squamous epithelium from the mouth. Ciliated cells in bronchial aspirates may sometimes become distorted and give corresponding trouble in diagnosis, unless they are familiar to the examiner.

Not only can the presence of cancer be accurately detected in about 90 per cent of positive cases, but it is possible to diagnose the type of carcinoma with an accuracy of about 80 per cent. High accuracy is obtained in the case of epidermoid and anaplastic carcinoma, but the figure is pulled down by the pleomorphic and terminal bronchiolar types. Adenocarcinoma poses the question as to its being primary or secondary in the lung. Epidermoid carcinoma usually presents distorted squamous cells with an increased keratin content, while the small, lymphocytoid elements of anaplastic carcinoma are generally quite diagnostic. Pleomorphic carcinoma is a loose group into which very bizarre tumors with very little differentiation of their cells are consigned for convenience. As many epidermoid and adenocarcinomas may show distinct pleomorphism, this leads to some confusion. Terminal bronchiolar carcinoma and the slowly malignant "tracheal adenoma" are seldom correctly diagnosed as such, although their presence as malignant tumors is usually correctly estimated by cytologic examination.

#### CONCLUSION

Exfoliative cytology is a reliable medium for the diagnosis of pulmonary carcinoma. It is very simple in application, any pathologist who will take the time to adjust his judgment to individual cells, rather than to tissues comprised of these, can become proficient in its practice in a few weeks. Those pathologists who have made it a practice to judge the cell as well as the tissue when performing diagnoses on tissue sections will slip into the cytologic groove with amazing ease. The method requires no elaborate instruments or apparatus and it can be carried out in a small room with an adequate sink. By requesting cytologic examinations, physicians will automatically create a necessity for the training of cytologists and an integration of their services into the laboratories of hospitals and clinics.



## THE ETIOLOGY AND TREATMENT OF ANXIETY STATES

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### PATHOLOGICAL FEAR AND ANXIETY

When fear and anxiety serve to protect man against danger these emotions are useful and normal. It is only when fear and anxiety do not serve a useful purpose that they are abnormal and pathological. It is common practice in psychiatry to define fear as the emotional response to external danger. The term anxiety is usually reserved for states of deep foreboding accompanied by tension and apprehension for which the patient has no explanation. Anxiety, long before it produces psychiatric illness, signals itself clinically by persistent functional symptoms—continued periods of fatigue, emotional distress, increasing irritability and difficulties in getting along with others. It is during this period of “build up” that anxiety should be recognized and treated promptly. It is as true in psychiatry as it is in medicine or surgery that the earlier a pathological condition is recognized and treated the more gratifying will be the clinical results. Once an anxiety state has developed, if it remains untreated, it may be expected to increase in severity until the patient’s emotional reserves have been exhausted and his capacity to adapt himself to life severely injured or destroyed.

While the introduction of curative drugs has reduced the morbidity and mortality rates of infectious diseases, there has not been comparable progress in the field of functional illness. It is recognized that functional illnesses have their sources and origins in the stress situations and frustration experiences in the life of a patient. These illnesses fall within the anxiety spectra in the life of patients and center about various circumstances such as (1) overwhelming environmental stress, (2) broken homes, (3) withdrawal of love and affection, (4) sibling rivalry and jealousy, (5) rejection in a love relationship and (6) failure to gain a life goal.

### PSYCHOTHERAPY

Anxiety may result from any stress situation in the life of a patient and is common not only to ill-

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### SUMMARY

- (1) Emotional security is the product of emotional growth and training within a family setting.
- (2) The path leading to security is one that must first be pointed out by parents, by teachers and by peers.
- (3) The family, the school, the church and our manners and customs of life are the background milieu in which growth to emotional security occurs.
- (4) Freedom from disabling anxiety reflects learned skills and is a product not only of the individual's adaptability potentials but of his total life experiences.

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ness but to daily living. Pathological anxiety of the type that can result in a fixed emotional illness has its sources and origins usually in those particular frustrating situations that threaten an individual's hopes, wishes and expectations in life. Furthermore the stress situation must be of such a nature that it also threatens the individual's prestige and sense of achievement and it must be of such a nature from which he cannot escape nor avoid nor solve without it destroying his hopes or wishes or threatening his prestige in life. Since hopes, wishes and feelings of achievement and prestige are all learned they are products of our culture and are determined by customs, manners and ways of life. To the degree that our own sense of values differ, patients differ individually in their frustration thresholds. It follows that to appreciate anxiety as it exists in any patient it is as essential for the physician to be acquainted with the patient's cultural and social conditioning as it is for him to understand the patient's life history and personal relationships. Patients are particularly

vulnerable to developing fixed anxiety reactions when they begin to feel uncomfortable with themselves and with other people and when they no longer are able to meet successfully the demands that life makes upon them. This is a first point for the physician to bear in mind whenever a patient seeks advice. A second point is to remember that functional somatic symptoms are the body's way of signaling the presence of a conflict and stress problem in the patient's life for which the patient has no satisfactory explanation. Once the physician has determined the functional nature of the patient's complaint, there are two courses that he can follow: one is negative and injurious to the patient, the other is positive and helpful. The negative approach is to reject the patient and his complaint with the statement, "There is nothing wrong with you." The other is to take therapeutic advantage of the doctor-patient relationship and move actively in a positive way to meet the patient's "Wish To Be Helped." The move towards helpfulness is psychotherapy. Every physician is to some degree a psychotherapist. A most important point in psychotherapy is the sincerity and desire on the part of the physician to be helpful. The emotional attitude on the part of the physician towards his patient and his problem, in many cases, determines whether the physician can or can not be helpful to a patient with functional symptoms. If the physician is insecure, defensive, authoritative, rejecting or angry he will not be helpful to his patients, and if the physician has the emotional capacity to become identified and interested in the patient's problem, and if he is capable, through his attitudes, of conveying to the patient a realistic sympathy and a warm desire on his part to help the patient with his problem, then the patient's frustration will be lessened and a helpful therapeutic climate will be established. At all times common sense judgments must prevail in the doctor-patient relationship. The question may be asked that if the causes of the patient's anxiety are unconscious and the patient is only aware that he is ill because he has functional somatic complaints, what procedures can be taken for the physician to become understanding of the conflict situation. Through acceptance of the patient and by willingness to listen to his patient talk over his troubles, the physician can through his patience in listening wait patiently for the patient to spontaneously reveal the conflict situation. With certain acquired skills, all centered on the physician assuming a permissive, friendly, supporting role, the

patient can be led to discuss his close interpersonal relationships freely. The physician should bear in mind that critical personal relationships involve parents, siblings, the personal love relationship in the life of the patient and his relationships with his bosses or superiors.

In psychiatry there are numerous theories and schools of thought as to the origin of pathological anxiety. There are theories that stress infantile sexuality and faulty psychosexual development as the main sources of anxiety. In these theories early childhood experiences and intrapsychic conflict growing out of parent-child relationships and repression are stressed. There are other theories which stress the role of the total life experiences of the patient and emphasize the impact of the individual and his instinctive drives against the cultural forces operating in the life of the patient. These theories stress the interactions and transactions of forces within the individual and within the cultural milieu.

#### CONFLICTS WITHIN THE AFFECTIONAL RELATIONSHIPS

While the factors of heredity, constitutional predisposition and physiological imbalance are also acknowledged underlying any anxiety reaction, this paper will be directed to discussing the role of difficulties in the interpersonal relationships in the life of the patient. This might be referred to as conflicts within the affectional relationships in the life of the patient. It is hoped that such an approach will serve the practical purpose of permitting physicians and surgeons to develop within themselves clinical skills in applying this type of an analysis to their individual patients and will give the physician an added insight into his patient's problem through his better understanding of the disturbances in the interpersonal relationships in the life of the patient. These disturbances in interpersonal relationships that are significant for this purpose may be said to involve only those disturbances that threaten the emotional or personal security of the patient. For children and adolescents the disturbance in interpersonal relationships must therefore necessarily revolve around the conflicts in the child-parent relationships. For adults the conflict in interpersonal relationships revolves around the relationship with a beloved person with whom the patient is in a frustrating relationship or with a person who holds the position of a boss or superior and who is in a threatening relationship to the patient. For children the emotional conflicts revolve around all those relationships, both positive and negative, with mother, with father, and with



brothers and sisters that can give rise to jealousy, hostility or rejection within the family group. For adults the emotional relationship that is significant is with the beloved person; for the wife, the husband; for the husband, the wife; for the lover, the mistress; for the mistress, the lover; and for the individual who is emotionally isolated and lacking in affectional skills it might be the phantasy or image of a loved person. All individuals also have the problems of others who are their bosses or superiors. The moment that a boss or superior changes his role from friend to foe, and if it is impossible for the individual to escape from his influence, the continued emotional repercussions to such a threatening person can give rise to intolerable hostility; the repression of which can lead to illness. The problems of guilt, frustration, hostility and aggressiveness, which must be repressed if we are to live in mutual helpfulness with each other, are recognized. The repression of such feelings, because of the demands of our social life, may under proper circumstances lead to states of chronic emotional tension and fixed frustration patterns. Then emotional tension can be brought to bear on any part of the body by means of the cortical, thalamic, hypothalamic, autonomic and sympathetic pathways and through stimulation of the adrenal, thyroid and pituitary systems. Ultimately this may lead to structural changes ranging from ulcer to colitis or from cardiac overactivity to rheumatoid symptoms. Continuous faulty habit patterns of thinking and feeling are capable of precipitating such psychosomatic states and result in structural bodily changes. It is to be admitted that the precise relationship of emotional stress factors, neurogenic activity and hormonal factors have been subjected to great study and are not understood clearly. These have been discussed by Selye extensively. It is of interest to note that the relationship between emotional factors and ulcer was noted as early as 1913 by Von Bergman. One of the great unsolved problems at present is "What is it that causes some patients under stress to develop preponderantly somatic symptoms and structural body changes, whereas in others the stress factors result in functional psychiatric illness, namely, the psychoneurotic disorders and the functional psychoses?" Clinically it can be observed that patients react to stress situations by actions that lead either to attack or to retreat or by developing submissive attitudes. It is important for the physician, in his appraisal of his patient, to clinically decide which of

these types of psychological defenses are being employed by the patient because the treatment of the patient must be directed with this in mind.

The aggressive, angry patient who is attacking his problem, or what he thinks is his problem, frequently makes the physician the object of his anger and uses the doctor as a whipping post. The secure physician understands this as a phenomena of projection, displacement and reaction formation and does not feel personally involved. By the physician's acceptance of the patient and his anger, just as he is, and by the physician's failure to become involved in his patient's anger the patient is helped.

The patient who is fear ridden and retreating from his problem must not have his fears increased by the physician's authoritative manner or threatening ways, instead this patient likewise must be led out of his anxiety and fear by first making him feel secure in his knowledge that his doctor will give him help as he needs help.

#### ABNORMAL SUBMISSIVENESS

The patient who comes to the doctor with dependent, submissive attitudes and who seems resigned to his illness is the most difficult to treat. These individuals take refuge in their somatic symptoms, they fix their attention on bodily symptoms, they rationalize, intellectualize and are guilty of self deception. The dependent, submissive patient reflects poor childhood conditioning and frequently has experienced in his infancy and childhood rejection and punishment beyond his capacity to adjust to it. So important is this problem clinically that it would be well to define abnormal submissiveness so that it might be recognized. Patients with the problem of abnormal submissiveness deny their own capacity, they avoid competition and seek continuous help, they are unable to be effectively aggressive and are lacking in positive motivation. Behind their somatic symptoms and hypochondriasis are repressed, hostile impulses and strong feelings of guilt. They are frequently kindly and ingratiating as well as very suggestible. Behind all of these reactions there are always factors of rejection in close emotional relationships and confusing unsatisfying emotional experiences throughout life marked by disturbed family relationships and unstable conditioning. These patients lack skills in belongingness and in their ability to communicate their thoughts and feelings to others.

Patients who respond well to psychotherapy are

those who have had secure family relationships from infancy through adolescence and who have developed affectional skills which allow them to be emotionally close to and part of another human being; and who have been culturally conditioned to the ideals of their family and social groups; and who have been conditioned to belong not only to their family and to each other but to their groups.

It is difficult to bring help by psychotherapy to patients who have been repeatedly crushed by life's

experiences to the point that they consciously and unconsciously expect only failure in the future, and to patients whose life situations and family relationships are hopelessly tangled in terms of conflict. It is equally difficult to bring help by psychotherapy to those patients who have never had a close family relationship or who have never experienced emotional warmth and belongingness and who have developed personality structures that reflect only disturbed human relationships.

## ANURIA: CASE REPORT

THE conference today concerns the patient Mr. J. A. D., sixty-seven years of age, who was admitted here December 1, 1953, at 5:00 P. M., in complete anuria and uremia, with an additional diagnosis of diabetes and a question of diabetic acidosis.

This patient was transferred by ambulance from another institution after having been hospitalized there overnight. There is no history available or obtainable since the patient lived alone in a hotel room. The little information which we have is by hearsay and from a sister who saw the patient two weeks ago and found him to be apparently well at that time. She knew of no previous severe illnesses. In reconstructing the present illness, it appears that the patient was relatively well until just two days prior to admission here, when hotel personnel found him semicomatose in his room. His sister stated that he did not, so far as she knew, have diabetes.

### FIRST HOSPITAL DAY

On admission to this hospital the patient was obviously semicomatose, feverish, and dehydrated. A note which accompanied him from the other hospital mentioned that a urine they had obtained from him was 1.020 in specific gravity, contained 2+ albumin and bile, but no note was made of sugar or acetone determination in the specimen. His red count at that institution was 4.5 million, hemoglobin 13.5 Gm. (88 per cent), white blood count 15,100, with 58 per cent segmented polys., 15 stab forms and 27 per cent lymphocytes. By the time of admission to our hospital we were dealing with a complete anuria. To compound the issue, there was evidence of pneumonic infection

## Diagnostic and Therapeutic Problems

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### SUMMARY

A case of total anuria in a sixty-seven year old male due to lower nephron nephrosis which was presented at medical conference is discussed from the diagnostic and therapeutic points of view. Pertinent autopsy findings are included.

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in the right lung, the question of diabetes, the lack of history concerning previous illnesses such as kidney disease, hypertension, etc. There was no history available concerning the possibility of the ingestion of drugs or the drinking of noxious agents; he was a known alcoholic, however. Other reports on the abstract from the previous institution were a fasting blood sugar of 174, NPN of 114, and a creatinine of 3.5 mg. per cent.

Physical examination on admission here revealed the general findings as noted. Blood pressure on admission was 96/70, temperature 102 degrees, pulse 106 but of fair quality, respirations 30. Breathing was not of the Kussmaul type. The eyeballs were moderately soft, the tongue dry and furry, but the breath was not "fruity" in odor. The skin was dry and wrinkled, the extremities were cold, dusky, and cyanotic in appearance. The fundi were relatively clear. The neck was supple. The heart was not remarkable. Examination of the lungs revealed relative dullness, bronchovesicular to bronchial breathing over the right lower

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lobe, but no rales over either base. A catheter was inserted into the bladder; no urine was returned. A repeat blood pressure done a few hours later was 92/60 and the heart sounds were then noted to be of varying intensity and the rhythm somewhat irregular. The respirations were noisy. No urine at all was present six hours later at 11:00 P. M. the evening of admission, although the patient seemed more alert, was taking sips of water, and had received 1500 cc. of water with glucose and vitamins I.V.

#### SECOND HOSPITAL DAY

The next morning the patient's general condition was about the same. Portable x-ray of the chest revealed a pneumonitis at the right base. The pulse was now more regular, the urine output was still zero, even though he had had another claysis of 1000 cc. of 5 per cent glucose and sips of water by mouth. Late in the afternoon of the second day the patient was able to respond somewhat to questioning but was still obviously confused. The urine output was still zero that evening, twenty-four hours after admission. He was given another 1000 cc. of fluid by claysis. We were treating him as a "lower nephron nephrosis" as far as intake of fluid, proteins, and electrolytes was concerned, attempting to make up the deficit in which he arrived without pushing him into pulmonary edema. When he could take something by mouth, this route was preferred. A report of the carbon dioxide content of the blood was 15 mEq./L and he was given 1000 cc. of 1/6 molar sodium lactate I.V. Thus a total of 5000 cc. of fluid was given within the first twenty-four hours without any effect on urine flow. There was no evidence of failure, increase in venous pressure, edema, or moisture in the lung bases. He still appeared clinically dehydrated. Following this, the plan was to give him about 1000 to 1500 cc. of fluids daily.

The following laboratory data were available to us at that time: There was no urine. Hemoglobin was 14 grams, hematocrit 45 per cent. Total protein was not available. White blood count was 18,600 with 84 per cent polys., 14 per cent lymphs., and 2 per cent monocytes. Fasting blood sugar was 168 mg. per cent.  $\text{CO}_2$  was 15 mEq./L, BUN 84, and creatinine 5.5 mg. per cent. Blood sodium was reported as 154 mEq., chloride 123 mEq., potassium 1.7 mEq./L. The serum was negative for acetone bodies. An electrocardiogram taken at this time showed no evidence of severe hypokalemia and the laboratory report of the potassium level was interpreted as being suspect.

#### THIRD HOSPITAL DAY

On the third day of hospitalization the patient again seemed a bit more alert. His skin was warm and he was able to take some nourishment by mouth. He was on fluids containing carbohydrate and fat with vitamins by mouth; foods containing any considerable amount of potassium were avoided because of his anuria. He now began to pass small amounts of dark urine for the first time. Examination of this urine showed a pH of approximately 5, a specific gravity of 1.017 with 2+ albumin, no bile, no sugar, and no acetone. The sediment showed 10 red blood cells per high power field and many white blood cells with clumps—there was an indwelling catheter. Another repeat urine showed identical findings. A repeat  $\text{CO}_2$  was 18.6 mEq./L, chloride 117 mEq./L, and BUN 101 mg. per cent. Repeat

sodium on 12-3 and 12-4 were 151 and 149 mEq./L, respectively. The potassium on 12-3 and 12-4 repeated was reported back as 7.85 and 7.1 mEq./L, respectively; these latter values for potassium were interpreted as being much more consistent with the clinical picture.

The temperature, which had been 102 degrees on admission, began to climb the second day to 103 degrees and thereafter hovered between 103 and 104 degrees. Along with this, the pulse rate increased to 130. An electrocardiogram revealed a pattern of myocardial ischemia, with numerous frequent interpolated premature auricular beats exhibiting the phenomenon of parasystole; it did not reveal a pattern specifically consistent with either hypo or hyperkalemia.

#### FOURTH HOSPITAL DAY

He was presented at this point at the medical conference on his fourth hospital day.

At the conference the question of diabetes was first thoroughly discussed, particularly since the admission note accompanying the patient from the previous hospital raised this question, and since their blood sugar was reported as 174 mg. per cent. It was pointed out, however, that any patient with anuria might present an elevation in blood sugar without diabetes; conversely, in a patient with diabetic acidosis, the resultant fluid and electrolyte loss could very well produce the picture of peripheral circulatory collapse and of renal shutdown which he presented. The level of blood sugar elevation does not rule out diabetes, although usually patients in severe diabetic acidosis do have a higher blood sugar and the urine flow is rarely completely shut down. Because of this question, however, the blood plasma was tested for acetone bodies with negative results. This, therefore, ruled out a true diabetic acidosis, but was consistent with the diagnosis of uremic acidosis. Serum acetone is a more reliable index than urinary acetone, since, in the presence of renal failure in association with diabetic acidosis, ketone bodies may disappear from the urine.

The infection and fever were discussed in relation to the problem from two standpoints, etiologic and therapeutic, first, because an alcoholic with pneumonia, severe toxicity, and dehydration could fall into the picture of circulatory collapse with anuria, and secondly, because infection and fever compounded the therapeutic problem, tending to increase the need for fluid and calories, with the associated dangers of excessive catabolic breakdown of tissue, i.e., increasing azotemia, retention of potassium, sulfate, phosphate ions, etc. One member of the group suggested the possibility of toxicity

and dehydration to explain the acute renal failure in this case; the apparently adequate concentrating ability of the kidney was noted. A discussion as to what would be the proper amount of fluid and caloric intake next ensued, especially with reference to the dangers of over hydration and over treatment, which very often throw these patients into failure and exodus. This patient, because of his age, cardiac and circulatory status, as well as alcoholic history, it was remarked, was not a good candidate from the standpoint of prognosis.

Acid-base balance and the presumed acidosis were next discussed as a therapeutic problem. In the face of anuria and excessive catabolism, these patients are very prone to metabolic acidosis. The diminished  $\text{CO}_2$  would seem to indicate such a state. These patients are very limited in their compensatory mechanism, being essentially arenal. They must rely upon  $\text{CO}_2$  excretion by the lungs, and vomiting, sweating, and diarrhea as outlets for excess accumulation of other ions such as chloride, phosphate, sulfate, sodium, and potassium. This patient was now taking some feeding by mouth and we were trying to limit his intake to glucose and fats as much as possible, with a total fluid intake of approximately 1500 cc. daily, the "extra" 500 cc. to compensate for his infection and increased metabolic rate. As his urine output increased, we were to increase his intake accordingly. He was given approximately 100 to 150 Gm. of glucose daily, plus added vitamins. He was on antibiotics as well in an attempt to control his pulmonary infection, which could have been the trigger mechanism. Interestingly enough, during the acute phase of a bacterial pneumonia there may be profound disturbance in electrolyte metabolism, characterized by depression of urinary excretion of sodium and chloride and a decrease in the concentration of sodium and chloride in the serum, due to some sort of unexplained physiological "segregation." In overwhelming infections, hyponatremia and hypochloremia may often be severe and associated with prerenal azotemia and shock. In this patient, however, we found a moderate elevation of both sodium and chloride on admission. Another physician at this point raised the question as to whether we really had a metabolic acidosis or a respiratory alkalosis in interpreting the low  $\text{CO}_2$ . Although one expects a metabolic acidosis in a case of anuria, a pure lobar pneumonia, because of the rapid, shallow breathing and the relatively bloodless state of the involved area of hepatization, may cause an excess

"blowing off" of carbon dioxide from the lungs, with a drop of  $\text{CO}_2$  tension and a shift in the blood pH towards alkalinity. This is not true for bronchopneumonia, however, where one characteristically finds the opposite, that is, a retention of  $\text{CO}_2$  because blood, in this instance, is circulating through the anoxic area of involvement in the lung. A blood pH is the final umpire in determining which exists in a particular case, it was pointed out. This patient, presumably having a bronchopneumonic process, would, therefore, be expected to have a respiratory acidosis superimposed upon an already existing metabolic acidosis.

The question of transfusions as a therapeutic measure in this patient was raised by the pathologist because he felt that originally, when this patient was admitted, he was probably in a state of shock. There was some discussion as to whether or not this was true, although he did have a moderate degree of hypotension, once as low as 85/60. He did not seem to be as acutely ill as one might expect in this condition, however. At this point another individual raised the question as to whether, in the face of dehydration and infection with temperature, one would expect to see the ordinary picture of shock. Shock is a syndrome due to many wide and varied causes; it is characterized clinically (except in hemorrhage) by hemoconcentration, hypotension, hypothermia, and depression of the central nervous system. One cannot, however, by the presenting clinical picture of shock, always determine the cause. In some cases the onset is sudden and dramatic, in others, insidious. In the type of shock characteristic of severe overwhelming infection the insidious onset is typical, and signs of circulatory insufficiency will be present for some days or hours before respiration ceases. The blood volume is fundamentally not at fault in these cases, and the capillaries are not abnormally permeable; the disturbance would seem to be primarily related to diffuse metabolic cellular breakdown. This type of circulatory failure may be reversible to a point if the process causing the abnormality, viz., the infection, can be controlled. Plasma or whole blood in these cases is not effective. Shock in pneumonia is a complication of severe toxemia and indicates a serious prognosis. The circulatory disturbance is characterized by hemoconcentration and increased, rather than depressed, cardiac output and peripheral vasodilatation. The skin, particularly of the extremities, is cold and moist and exhibits a characteristic gray cyanosis. If maintained



for sufficient length of time it becomes irreversible and the patient dies in shock, even though the infection may be finally controlled. In this case we explained that our hesitancy in giving transfusions was predicated upon the fear of potassium release in the event of a hemolytic reaction, which, with anuria, would be fatal. An additional question in reference to the patient's state of hydration on admission was raised at this point, i.e., whether a blood volume would have given us important confirmatory information as to body water "debt." This is more reliable than total protein, hemoglobin, and hematocrit determinations in patients where there is no preceding information concerning nutritional status or anemia.

An outline was presented of the common causes of urinary suppression. These were briefly listed as follows:

(1) \*Sustained shock or circulatory collapse due to:

Blood loss.

Severe trauma, especially crushing injuries.

Burns.

Severe infections.

Severe dehydration.

Anesthesia, especially prolonged.

Surgical procedures.

Obstetrical complications.

Transfusion reaction.

Allergic or toxic reactions to sulfonamides.

Hepatorenal syndrome.

Drug poisoning (carbon tetrachloride, mercury, industrial poison).

(2) Acute glomerulonephritis and chronic glomerulonephritis in the terminal stage.

(3) Acute and chronic ascending pyelonephritis and necrotizing papillitis (diabetics).

(4) Reflex anuria from instrumentation or calculi in the urinary tract or from emboli or thrombi in the renal vessels.

(5) Congenital malformations of the kidney such as polycystic disease (in the final stages).

(6) Obstruction to renal flow from sulfa drugs as the result of physical crystallization in the tubules.

(7) Stag-horn calculi, carcinoma, or any type of obstructive pathology in the region of the renal pelves or ureters, bilaterally.

(8) Oliguria (less likely anuria) occurs during the stage of rapid accumulation of edema fluid.

It would seem that the most likely diagnosis here was that of lower nephron nephrosis based upon a substrate of severe overwhelming infection and associated dehydration, in an elderly, malnourished individual who had apparently been in semicoma or stupor for a few days before receiving medical attention. There was no known history of preceding hypertension or kidney disease to implicate chronic glomerulonephritis in the terminal stage; the specific gravity was too high for this possibility and the onset too abrupt. It is to be noted, however, that the usual case of lower nephron nephrosis also exhibits a urine of specific gravity approximating 1.010 when renal failure has been established. Necrotizing papillitis might have been an explanation if the patient were diabetic. An acute glomerulonephritis with secondary tubular degeneration was considered a possibility, but here again one would expect a preceding upper respiratory infection with a latent period, a more gradual onset, edema, hypertension, eyeground changes, and a more characteristic urinary sediment. Carbon tetrachloride poisoning should always be thought of in an alcoholic, although again no history was available. The most likely possibilities in this case, therefore, were considered to be:

(1) Severe toxemia and dehydration, with associated circulatory collapse and lower nephron nephrosis.

(2) Possible carbon tetrachloride poisoning.

(3) Terminal phase of a basic chronic glomerulonephritis.

The treatment of lower nephron nephrosis is divided into three phases: (1) phase of shock, (2) phase of anuria, and (3) phase of diuresis. Since this man was in the anuric phase of his disease, retention of water, metabolites, and electrolytes was the essential therapeutic problem and the discussion as to treatment was restricted to this phase of the disease. As regards the general aspects of treatment of acute renal failure, many of them have been touched upon above. Some additional notes should be made in regard to special problems. As a rule electrolyte patterns should be maintained as close to normal as possible, as should total water content. Potassium deviations must be especially watched for in either direction; with anuria one expects an elevation, with diuresis, a fall in the blood level. Sodium chloride

\*All the above, by the common denominator of shock, produce the syndrome which of late has been called "lower nephron nephrosis."

should not be used as such except in specific cases; for acidosis, sodium bicarbonate or sodium lactate is used instead, with a careful eye on water retention and edema. Daily weighing is a useful procedure. Diuretics and over hydration are strictly contraindicated. Therapy directed towards increasing the renal blood flow, such as sympathectomy and spinal anesthesia, are of no avail. Renal decapsulation theoretically could be of value in the cases where the kidneys are greatly swollen and ischemic. The use of the artificial kidney and peritoneal lavage are excellent but limited because of procedural difficulties. Intestinal dialysis in the upper jejunal loops, however, is a more practical measure and is particularly useful in relieving potassium ion elevation.

#### FIFTH HOSPITAL DAY

Course: On the fifth day of hospitalization the patient's temperature increased to 105 degrees, the pulse became more rapid, between 130 and 140, the patient went into what appeared to be congestive failure and died rather suddenly. Autopsy was obtained.

The pertinent autopsy findings were as follows: The coronary arteries, although they showed considerable mural atheromatosis, were not narrowed at any point. The renal arteries showed no evidence of narrowing or thrombosis. The renal veins were likewise clear and widely patent throughout. The kidneys were of normal size. Their capsules were stripped with considerable difficulty, revealing a finely pitted surface. On section the cortex was normal in thickness but very blurred, the entire cortex appearing somewhat yellowish, cloudy, and swollen. Cortico-medullary differentiation was blurred. The medulla was, however, unremarkable. Pelves were unremarkable. The liver was

mildly shrunken. On section it showed a uniform yellowish coloring throughout and was otherwise unremarkable. The lung showed a right lower lobe bronchopneumonia with considerable atelectasis. The remainder of the gross examination was unremarkable.

Microscopic examination: Sections of the kidney showed scattered hyalinized glomeruli, together with a few partially hyalinized units showing old fibrosis, epithelial crescents, as well as capsular and glomerular adhesions. Small zones of scarring were seen near the surface. Scattered, greatly dilated tubular units were visible and within several of these changed glomeruli and tubular units moderate amounts of coagulated protein were seen. The remainder of the glomeruli showed a moderate degree of hypercellularity, with the appearance of distorted nuclei resembling those of leukocytes. This was particularly common in the stroma at the root of the glomerular unit. The preglomerular vessels showed no uniform pathological change. The tubule cells showed a uniform graying and liquefaction of the cytoplasmic edges with reduction in total volume; they appeared thinned and flattened. In a very few places focal regions of early regeneration with hyperchromatic nuclei and eosinophilic cytoplasm could be seen. Within the lower portion of the loop of Henle there were seen scattered hyaline casts with compression of the surrounding tubular epithelium. There was no evidence of interstitial inflammation, edema, or active regeneration. Sections of liver showed a moderately extensive cirrhosis of the portal type with fat accumulation within hepatic cells. There was no evidence of necrosis, regeneration, or inflammation.

The pathologist's opinion was as follows:

Cause of death: Uremia due to lower nephron nephrosis.

Contributory factor: Bronchobulbar pneumonia, right lower lobe.

## AURICULAR FLUTTER AND FIBRILLATION

### A Critique of Current and Classical Concepts and their Clinical Implications

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#### SUMMARY

An evaluation of the mechanism of auricular arrhythmia in the light of more precise present day methods strongly suggests that auricular flutter and fibrillation often, but not always, result from a rapidly discharging single ectopic focus.

Equally valid evidence seems to substantiate the

concept that experimental as well as clinical auricular arrhythmia may arise from a circus movement mechanism.

Analysis of the data presented by the various schools indicates that both mechanisms exist clinically and that they may, indeed, exist in the same auricle through the establishment of secondary centers.

The uncertainty of response to anti-arrhythmic drugs is due, in large measure, to the differences in effect of these drugs on the two types of underlying



irregularity when other circumstances of oxygen supply, electrolyte balance and auricular distension are taken into account.

Deductions are drawn to indicate that circus movement auricular arrhythmia requires maximum serum concentrations of quinidine for successful reversion, and that this carries the risk of serious toxic effects of large doses of this drug, as encountered occasionally.

Similar deductions suggest that the ectopic focus type of arrhythmia is not as firmly fixed a pattern and reverts to sinus rhythm more often either spontaneously or with comparatively small doses of the various anti-arrhythmic medications.

In view of the desirability of restoring normal sinus rhythm whenever possible because of the improved cardiac efficiency, more extended use of quinidine under electrocardiographic and blood level control appears to be the regimen of choice.

In instances where reversion is not possible or not practicable, ventricular control with digitalis improves cardiac function.

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**I**N 1909, Rothberger and Winterberg<sup>2</sup> were the first to publish satisfactory evidence that auricular fibrillation occurs in human patients; their publication antedated by only a few months the independent demonstration by Lewis<sup>1</sup> that auricular fibrillation is a common clinical condition. Since 1909 this arrhythmia has assumed increasing prominence. It is rated first in hospital statistics and constitutes an ever present concern to the clinician irrespective of its origin. Because of differences in opinion as to the mechanism of this disturbance, controversy concerning its rational management remains. Though auricular fibrillation is a readily detectable disorder, the patient who manifests this irregularity poses the following problems: Is reversion to normal sinus rhythm desirable, or even feasible? Is cardiac function impaired in auricular fibrillation with a slow ventricular rate? Are attempts at reversion fraught with added dangers?

Until the recent work of Prinzmetal<sup>3</sup> and his associates, the mechanism of auricular fibrillation was presumed due to circus movement, as postulated by Lewis. On it rested our regimen of digitalis and quinidine, and except for observers such as Brill and Katz and Scherf, failures of therapy were attributed to uncontrolled and unpredictable variants in the disturbed physiology which prevented disruption of the circus movement.

It is the purpose of this paper to scrutinize the classic concept of Lewis<sup>2</sup> and the more recent theory of Prinzmetal,<sup>3</sup> to indicate that the latter is not free of fallacies, and that both concepts are probably correct to some degree.

In order to comprehend the nature of the arrhythmia several factors must be considered. Among these are rate, strength and duration of stimulus, threshold of excitability of muscle fibers, and duration of refractoriness of the conducting tissues. An understanding of these factors is dependent upon a comprehension of the basic structural, biochemical, and electrophysiologic facts implicated in the function of cardiac muscle.

#### PHYSIOLOGY

All cardiac muscle has the property of intrinsic rhythmicity and conductivity. There is a normal gradient of rhythmicity, maximal at the S-A node, and minimal in the ventricle muscle. An impulse, once formed at the S-A node, is conducted through the auricular musculature with the inscription of the 'P' wave of the ECG. The impulse is then conducted to the A-V node, where its passage is temporarily inhibited, represented by the P-R interval. From the A-V node, the impulse passes to the ventricle via the bundle of His and its two branches to the subendocardial Purkinje plexuses. The stimulation of the ventricular muscle and its depolarization are represented by the QRS, the repolarization by the T wave. During the isoelectric T-P interval, the biochemical phenomena preparatory to impulse formation are occurring in all of the conducting mechanism, but maximally in the S-A node. Normally impulses are conducted at a regular rate of 50-100 per minute. An arrhythmia may arise in the course of an active or passive disturbance. In the passive form, depression or suppression of the primary pacemaker permits a subordinate center to become dominant in the control of rhythm. In the active type, local alterations in cellular physiology create an irritable focus or foci which interfere with the normal transmission of sinus beats. This results in isolated interference or, if sustained, dissociation. The properties of conductivity and rhythmicity are dependent upon the refractoriness of the area stimulated. Immediately after systole the muscle fibers are absolutely refractory, i. e., no response follows any stimulation until an interval of time has elapsed. During the latter part of the cycle a response may follow a stimulus of greater intensity than that required during the non refractory phase. This is

the relative refractory period. The duration of refractoriness is influenced by neural, hormonal and nutritional balance, by oxygen supply, salts, drugs, and metabolites. The opposite of refractoriness is irritability, the cyclic phases of heart muscle passing from non irritability through relative irritability to irritability. Cardiac muscle fibers are specially endowed with this property of irritability which eventuates in contraction.

The force of contraction varies with the initial length of the fibers, oxygen supply, viscosity of blood contracted upon, and nutritional state of the muscle fibers. Within certain limits Starling's law obtains, and the force of contraction increases proportionately with the diastolic length of the fiber.

What is the exact nature of muscle contraction? Current thinking relates this to a reorientation of actomyosin within the myofibrillae. The protein, actomyosin, under circumstances of increased temperature or decreased pH, undergoes a reversible coagulation. The individual molecules are transversely, rather than longitudinally oriented, with a resultant shortening of the muscle fibers. The lowered pH which effects the aforementioned sequence of events is rendered possible by the breakdown of phosphocreatine into adenylic acid, adenotriphosphate and lactic acid. With the retention of oxygen by myoglobin, phosphocreatine is resynthesized, the pH reverts to normal, and there results a longitudinal reorientation of the actomyosin molecules. This, in turn, results in the diastolic elongation of the myocardial fibers.

The biochemical and biophysical events described are dependent upon the maintenance of an adequate blood supply to the myocardium. The blood supply to the individual heart muscle fibers is safeguarded by: (1) intercoronary anastomoses, (2) anastomoses between branches of coronary arteries and other branches of the aorta, (3) retrograde flow via the coronary sinus and veins, (4) the thebesian vessels. The flow of blood and resultant oxygen through these channels is a phasic phenomenon largely dependent upon the resultant of two factors, the aortic blood pressure, and the state of the coronary vessels. Maximal flow occurs during diastole. Any factor which curtails the diastolic period such as supra-ventricular arrhythmia, or tachycardia, significantly reduces coronary flow. Pertinent to a discussion of coronary blood flow are agents which increase or decrease it. The former are represented by oxygen, thyroxin, digitalis (in nontoxic amounts), epine-

phrine, nitrites, papaverine, and atropine. The latter are represented by pituitrin, pitressin, and reflexes through distention of abdominal viscera. Quinidine has no direct effect upon coronary flow, but may influence it, secondary to its influence upon cardiac rate and rhythm.

#### NERVE SUPPLY OF THE HEART

Innervation of the heart has been shown to be twofold, extrinsic and intrinsic. The extrinsic nerve supply is derived from the vagi and the cervical sympathetic trunk. Efferent cardiac nerves from the vagal ganglion nodosum and ansa hypoglossi and from the superior, middle and inferior sympathetic ganglia form complex, superficial, and deep plexuses behind the base of the heart. Fibers from the right cardiac nerves supply the sino-auricular node and auricular muscle. The ventricles and atrioventricular conduction tissue are supplied almost entirely by the left cardiac nerves. In animals it is well established that the stimulation of the vagus nerves slow impulse formation and conduction and contraction by increasing refractoriness and lowering irritability. The sympathetic nerves oppose these actions. The afferent cardiac nerves are much less well delineated. Myocardial nerve anoxia stimulates the termini of afferent nerves, with the passage of impulses to the dorsal root ganglia in the cervical and upper thoracic spinal cord segments. These synapse with neurons on cell bodies in the dorso-lateral or intermediolateral columns of the gray substance. Efferent sympathetic fibers originate here and pass via white rami communicantes to sympathetic ganglia, from which gray rami conduct the impulse to the vasa nervosum of peripheral somatic nerves. Spasm of these vasa nervosum results in ischemia of the somatic nerves and with it the sensation of pain.

The mechanism of cardiac automatism remains, to this date, a disputed problem. The neurogenic theory, as proposed by Willis in 1660, and the myogenic theory, fostered by Heller in 1759 remained the two opposing schools until the recent work of Glomset<sup>7</sup> who demonstrated in man, monkey, dog, swine, sheep, horse, and cattle that there is no clearly defined conduction system, and that transmission of impulses is effected through nerve ganglia, as originally postulated by Rewak in 1838.

#### GENESIS OF AURICULAR FIBRILLATION

Having discussed the basic factors underlying the normal cardiac mechanism, let us now turn our



attention to those underlying the abnormal patterns, especially in the auricular portion of the heart. Because the concept of a single focus center postulates a unitary basis for all of these disturbances of rhythm, it may be well to inspect the several auricular arrhythmias. There may be an increase or decrease in the rate of normal stimulus formation. A new center may initiate impulses—heterotopia, which includes A-V nodal rhythm, parasystole, interference and dissociation. Finally, an entirely abnormal type of stimulus formation as in extrasystole, paroxysmal tachycardia, flutter and fibrillation may occur.

**Extrasystoles:** Normally the sinus node has the greatest rhythmicity and the capacity for impulse formation progressively decreases as one approaches the apex of the heart. Furthermore, a stimulus formed in the sinus node, as it spreads over the heart, invades other more slowly paced centers and discharges the stimulus material accumulating there. Forming the highest number of stimuli gives the sinus precedence. If through change in innervation, blood supply or other factor, the sinus node is inhibited, the secondary centers are free to originate and transmit stimuli. In addition, a special fiber or group of fibers can be altered so that it becomes more irritable than normal and emits effective stimuli. Whether these extrasystoles are really released independently and automatically or whether they are bound to the preceding regular beat is still a matter of dispute. That they originate in a sharply circumscribed area is borne out by the fact that warming of the known area of irritation increases the number of extrasystoles to the point of producing paroxysmal tachycardia.

**Auricular Flutter and Fibrillation:** In the laboratory animal, stimulation of the auricle such that it contracts at the rate of 300-400 times per minute results in auricular flutter; when the rate reaches about 600, auricular fibrillation occurs. Regular f-waves appear in the electrocardiogram and the ventricles will follow at a varying rate. Prinzmetal has described, in auricular fibrillation, M waves, minute irregular contractions, and L waves, large rhythmic contractions which seem to correspond to the f-waves in the electrocardiogram. Auricular flutter and fibrillation can readily be reproduced in the laboratory. Two methods are currently employed: one is the method of Scherf in which .05 cc. of .05 per cent solution of aconitine nitrate is injected subepicardially near the tip of the right

auricle. This author has reported, with confirmation by other investigators, that cooling the site of the aconitine injection decreases the auricular rate. Stretching of the auricle often increases the rate. Furthermore, it is found that if the aconitine-containing segment of the auricle is ligated the arrhythmia disappears, with reappearance in release of the clamp. This would suggest that blood supply plays a large part in impulse propagation. The other method is that of Rosenblueth<sup>9</sup> and Garcia-Ramos in which flutter is initiated by brief, rapid, electrical stimulation near a crushed area in the right auricle. On superficial observation the same abnormal mechanism is set up by both of these modalities. There is some question, however, as to whether this similarity is as valid as it appears. This will be reviewed later in this discussion.

The clinical counterpart is still the subject of much dispute. Two concepts of auricular fibrillation have attracted attention, the circus movement theory first propounded by Lewis and the ectopic-focus interpretation first proposed by Rothberger<sup>2</sup> and Winterberg and recently revived by Prinzmetal and his group.

**Circus Movement Theory:** This is defined as the rapid, regular passage of a single impulse around a relatively fixed path. In 1913 and 1914, Mayer and Mines showed that, in a muscle ring removed from a tortoise heart, a wave of excitation could be initiated by an induction shock which would spread in both directions and stop when the waves met. If, however, one stimulates at one point and simultaneously, by means of a clamp, compresses the muscle adjacent to the point of stimulation the wave of excitation proceeds but in one direction, the other side being obstructed. When the excitatory wave returns to the point of origin, and if, in the interim, the clamp has been removed, the wave circulates over the same pathway and continues to do so indefinitely. The excitation wave passes around several hundred times a minute; the smaller the ring, the faster the rate.

In 1920 Sir Thomas Lewis<sup>1</sup> applied these findings to auricular arrhythmia as seen clinically. In flutter, the pathway of the circus movement was demonstrated to follow a fixed course around the ends of the vena cavae in the right auricle at a rate of 300-400 per minute producing f-waves in the electrocardiogram that are regular in contour and rate. The ventricle responded to only a fraction of the stimuli transmitted from this auricle because the atrioven-

tricular node blocked every second or third impulse. This ventricular rate, therefore, would vary from 75 to 150 per minute. The "central or mother wave" circulated in the main path with daughter or secondary waves radiating centrifugally to excite the auricle and ventricle.

In auricular fibrillation the circuits of the circus movement are presumed to be small, numerous and constantly changing in pattern. Islands of refractory muscle appear with emergence of local dissociation, re-entrant waves and local circus movement.<sup>17</sup> This phenomenon is attributed to changes in the refractory state of the auricular muscle brought about by disturbances in vagal effect, electrolyte, local blood supply or oxygen content. In the electrocardiogram, the auricular complexes are small, of short duration, with no regularity of pattern, and at a rate that varies from 600 to 1,000 per minute. The ventricular response is slower than the auricular rate and is determined by the number of effective impulses that are transmitted from the auricle.

In the Prinzmetal<sup>3</sup> concept a single, ectopic focus emits a large number of impulses which travel out in all directions. Flutter and fibrillation were produced both by the electrical stimulation method and by the application of aconitine in the exposed auricle of dogs. These were then visualized with high speed cinematographs with camera speeds up to 2,000 frames per second. At the same time single and simultaneous direct lead electrocardiograms were recorded. The data presented, the authors have stated, are "proof beyond question that no circus movement is present in auricular flutter or fibrillation." They conclude that both the contraction and excitation waves arise from an ectopic focus and spread outward through the auricles in all available directions simultaneously. Furthermore, they maintain that the mechanism in premature auricular beats, paroxysmal auricular tachycardia, auricular flutter and auricular fibrillation is identical, the conditions are unitary in nature, and the sole difference is that of rate only.

#### RECONCILIATION OF CIRCUS MOVEMENT AND ECTOPIC FOCUS THEORIES

Analysis of the recent papers by Scherf<sup>5,21</sup> and his group and by Prinzmetal<sup>3</sup> and his group and the older papers of Lewis,<sup>1</sup> and more recently those of Rosenblueth<sup>9</sup> and Garcia-Ramos and those of B. Brown<sup>10,11</sup> leave one in a state of perplexity. The data all seem equally trustworthy and yet directly

contradictory. In the case of Prinzmetal's work it is noted that his recording is by monopolar electrodes, using a resistance-balanced neutral lead. His tracings reveal QRS and T waves indicating a pick up from the ventricular field. Hence, instead of giving an accurate picture of the impulse as it passes through the auricular musculature it is reflecting the changing influence of the neighboring electrical fields as the impulse traverses the auricle. Furthermore, with monopolar recording, as against bipolar used by Lewis, the f-waves show changes in amplitude and direction as the impulse crosses the auricle. This makes it difficult to correlate the wave form with the distance from the pacemaker. Also, Prinzmetal duplicated circus movement flutter by driving the auricle with electrical stimuli at flutter rates. This, of course, is not flutter and does not allow a single impulse. In addition, he made his analysis of wave form and velocity during this type of stimulation. This is, in fact, an ectopic focus continuously supplying impulses and does not simulate circus movement flutter. Further, Prinzmetal intimates that the rate of stimulation determines the rate of arrhythmia. This is contrary to the experience of his protagonist, Scherf, as well as of Brown and Acheson. Neither is it true, as Prinzmetal has asserted, that "experimental premature beats depend upon a specific relationship between rate of stimuli and sinus rate." A better explanation would invoke the relationship between rate, strength and duration of stimuli and threshold of excitability, variation in refractory period and rate of recovery of the conducting mechanisms. In another connection and speaking of the same group of Los Angeles investigators, Carl Wiggers<sup>8</sup> in the paper quoted above said, "It is a common experience in research that experimental results which seem crucial at the moment turn out to be inadequate with aging."

Rosenblueth and Garcia-Ramos<sup>9</sup> have demonstrated, and their work has been confirmed, that only a single impulse is concerned in circus movement and have delineated the pathway that the impulse follows. Prinzmetal has utilized aconitine-induced arrhythmia for most of his observations as has Scherf. This is admittedly an artificial, single ectopic focus which discharges a great number of impulses. This form of flutter has certain characteristics which differentiate its nature from that of the circus movement mechanism. The aconitine induced ectopic focus type is more gradual in onset, there is a tendency to irregularity between beats,



the change to sinus rate is gradual, the rate is independent of conduction velocity but varies with impulse production. The circus movement type of flutter, as produced by the Rosenblueth and Garcia-Ramos<sup>9</sup> method, on the other hand, is sudden in onset, i.e., within one cycle of previous rhythm, shows complete regularity between beats, the reversion to sinus rhythm is abrupt, and the rate is proportionate to conduction velocity.

The best explanation gleaned from this conflicting evidence is that both the ectopic focus and circus movement type of arrhythmia have been established experimentally and that they are two well defined, separate entities. Furthermore, both types may exist in the same auricle and one may evolve from the other. The problem at hand is to determine whether either or both resemble the characteristic of auricular arrhythmias which occur clinically.

If this thesis is correct, then the subject of auricular arrhythmias has made a complete swing around the circle. The work of Rothberger and Winterberg, and of Lewis—ectopic-focus mechanism and circus movement—both acquire substantiation by recent, more precise, experimental methods. It is not only possible, but probable, that both types exist clinically as well as experimentally and that the underlying etiological factors and therefore response to treatment will differ. This explains the conflicting and capricious behaviour of this clinical entity encountered at the bedside.

While this paragraph was being written, the June issue of *Circulation* came to hand. In it, R. Wenger and D. Hoffman-Credner record their experience clinically with direct leads obtained by cardiac catheterization and semidirect leads from the left atrium by the esophageal route. They encountered six cases of auricular flutter. "The finding in two of our cases of auricular flutter would agree with the theory of circus movement—the four other cases showed different findings which would speak more in favor of another mechanism of excitation." This is an example of two independent workers unwittingly encountering this enigma that is being presented here. In the light of our present discussion it may be said that they describe two instances of circus movement flutter and four cases of ectopic focus flutter.

**Effect of Vagal Stimulation:** The response to vagal stimulation varies with the auricular rate. In slow-speed auricular tachycardia, the effect is to terminate the rapid rate; in rapid-speed tachycardia

(auricular flutter) vagal stimulation often accelerates and may convert the arrhythmia into fibrillation. Scherf,<sup>5,21</sup> however, contends that vagal stimulation never terminates it. If it is assumed that the mechanism underlying the tachycardia is a rapid stimulus formation in a center rather than a circus movement then the increase in rate during vagus stimulation is an unusual phenomenon. The arrest of auricular flutter by vagus stimulation is rare, while it is a common occurrence in auricular tachycardia. In circus movement flutter, section of vagus causes no change in rate; stimulation of vagus in circus movement may increase, decrease or show no change. According to Lewis' theory of partial refractoriness, conduction velocity decreases at high rates of response because of a sinuous course of the advancing wave among islands of tissue which are still refractory. The vagus, then, depresses stimulus formation, conduction and contractility. It also causes constriction of the coronary arteries in the auricles but not in the ventricle. Ventricular effect is apparent only because (1) depression of stimulus formation in auricle, (2) alteration in coronary arteries, (3) acetylcholine—vagus substance—is diffused to the ventricle.

**Effect of Quinidine** is three-fold: 1—direct depression; 2—inhibition of vagus effect; 3—stimulation of sympathetics. In the circus movement theory, its effect is assumed to interrupt the excitable gap in the circus pathway and thus if successful, to restore normal rhythm. In other words, quinidine lengthens the conduction time and the refractory period and therefore decreases the rate of transmission. Large doses of quinidine and high auricular rate appear to raise the threshold of auricular excitability. On the ventricle, quinidine depresses the ventricular rate by depressing conduction of the functional tissues. If the vagus nerve is cut, the rate is unaffected by quinidine. In the ectopic focus theory, the effect of quinidine is a depression of the auricular activity in and around the ectopic focus. If the slowing thus induced occurs abruptly, direct conversion to sinus rhythm is achieved. If the rate declines slowly, flutter passes into tachycardia and as the rate becomes increasingly slower, normal rhythm is restored as the ectopic focus becomes less active than the sinus node. The depressing effect of the quinidine may therefore result from a slowing of impulse formation in the focus and/or the depressed conduction out of the focus.

**Effects of Digitalis:** Digitalis is presumed to have a threefold action: (1) vagotonic, thereby shortening

the refractory period of auricular muscle; (2) direct action on auricular muscle, lengthening the refractory period, and slowing conduction; (3) increase of block at A-V node. Under the circus movement theory, this would mean that the gap would be maintained while the circuit time of the wave would be shortened from the first effect; the second effect would be to close the gap and slow the auricular rate. The vagal effect usually predominates over the muscular resulting in the acceleration of the auricular rate, e.g., from flutter to fibrillation. However, the decrease in conduction at the functional tissues permits fewer impulses from passing to the ventricle from the auricles. The ventricular rate is therefore slowed. Aside from this there is a direct action of digitalis on the ventricular muscle in failure, increasing the force of contractions as well as increasing the diastolic phase with lengthening of the muscle fibers.

**Clinical Implications:** To illustrate the protean nature of auricular flutter and fibrillation, sixty consecutive and unselected cases were reviewed. These patients were observed by the author but not in all instances treated by him, both at the Stamford Hospital and at the office when ambulant. Of this total of 60, four were identified as flutter and 56 as fibrillation of the pure or impure type. Of the four cases of flutter, three were associated with congestive failure and reverted to sinus rhythm in the process of digitalization. One patient emerged from her congestive failure which was associated with rheumatic heart disease with a persistent flutter at an auricular rate of 300 and a ventricular rate of 100. Repeated attempts at reversion with quinidine in dosages up to 3 Gms. per day for five days brought about no change. Procaine amide by mouth and intravenously was similarly ineffective. The cardiac function is adequate for normal activities but tolerance for extra exertion is impaired. The patient insists that she is quite comfortable and refuses any further antiarrhythmic therapy, other than small doses of digitalis, because of the unpleasant side effects, tinnitus, nausea, diarrhea and urticaria. Her flutter has, as of this time, persisted for 63 weeks.

Of the 56 cases of auricular fibrillation, 32 were labeled persistent or chronic and 24 paroxysmal (less than one week in duration). In the first group the majority were over the age of 50. Three were under this range, aged 42, 38, and 18. Of the 32, 18 were diagnosed as rheumatic heart disease, 12 arteriosclerotic/hypertensive, and two masked hyperthy-

roidism, questionable. Digitalization was employed in the 18 cases with satisfactory ventricular control in all; in two reversion to sinus rhythm was observed. Quinidine was exhibited one day a week, 1 Gm. daily in five equal doses the first week and 2 Gms. daily on succeeding weeks. No reversions could be attributed to the use of quinidine in these persistent arrhythmias. Eight of the group of 18 died of various causes; some related to cardiac failure, others unrelated. The remaining 10 left the hospital still fibrillating. Of the 12 arteriosclerotic cases, ventricular slowing was accomplished in eight cases. Four of these cases expired and eight were discharged on maintenance doses of digitalis.

The two cases that were assumed to be thyrotoxicosis without overt signs, or masked hyperthyroidism, included two males aged 32 and 52. Tests for protein bound iodine and radioactive iodine elimination were not available. The basal metabolic rate in one was plus 16 and in the other plus 6. On trial doses of Lugol's solution, reversion to sinus rhythm took place within 24 hours. This may have been coincidental but Bortin, Silver, and others<sup>13</sup> have described similar experiences.

In the paroxysmal form, a wide range of possible etiological factors were encountered. In this group of 24, two were associated with emotional excitement and possible trauma of automobile accidents, in one case with chest compression. One case occurred at the time of a coronary occlusion and reverted the following day with no special attention. Eleven of this group were being treated for various acute infectious disorders. The remaining ten were unassociated with evidence of heart disease, i.e., no cardiac enlargement, no murmurs, no hypertension, hyperthyroidism or history of symptoms denoting previous cardiac disease. They were labeled the lone or idiopathic type with paroxysms of arrhythmia lasted from one-half to several days. Barbiturates and quinidine in 0.2 Gm. doses were given but no clear evidence was obtained that the paroxysms might not have been self limited. Of interest is the fact that two cases of cerebral embolism were encountered, in both instances before quinidine therapy was initiated.

#### CONCLUSIONS

In the light of what has been said earlier in this paper, some deductions can fairly be drawn from this representative group of cases. The chronic or persistent form of auricular fibrillation responds



only occasionally to anti-arrhythmic therapy, at least in doses currently employed. Control of ventricular rate, but not rhythm, with digitalis is readily accomplished and restores function to an adequate but not complete extent. Berry, Bellet et al.<sup>12</sup> have defined the ideal drug. "An ideal drug for treatment of rapid ectopic rhythms, should prolong the effective refractory period of the myocardium, should not produce areas of local block and should abolish this latter abnormality if present, and should not slow conduction through the specialized tissues of the heart." No such drug is as yet available. It may be that the more intensive use of quinidine, perhaps with the determination of plasma levels as advocated by Holzman and Brown,<sup>14</sup> by Acierno and Gubner<sup>16</sup> and by Yount et al.<sup>18</sup> may result in more consistent reversions, but the risks of toxicity appear at the moment to be a deterring factor. Procaine amide<sup>20</sup> appears to have quinidine-like action.

It must be added, however, that from the experimental evidence reviewed quinidine approaches the ideal in the ectopic-focus types of fibrillation, and is not so effective in the circus movement type. Because of the difficulty of differentiating readily these two types clinically and the probability that most of the protracted or chronic types are of the circus movement form, control of the ventricular rate with digitalis would appear to offer the best relief for the immediate problem of congestive failure or of the diminished cardiac output arising from the rapid arrhythmia itself. (Levine, etc.<sup>15</sup>) Stewart and Carter,<sup>19</sup> and others since their report, have shown that auricular fibrillation has deleterious effects upon circulation, with decrease in cardiac output. Cardio-respiratory efficiency was found to be greater with normal sinus rhythm even when the ventricular rate is slower than normal during auricular fibrillation.

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## CONCLUSIONS AND RECOMMENDATIONS OF COMMITTEES OF THE CONNECTICUT HEALTH LEAGUE

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### THE CARE OF THE AGED

IT has fallen to me to attempt to summarize a portion of the proceedings of yesterday morning's panel discussion on care and rehabilitation of the aged. It is the feeling of all the leaders in the field of chronic illness that no matter what resources are used to care for the person with long-term illness, the spirit of modern rehabilitation should pervade the rendering of service. This means simply that in the giving of all care we must have in mind the maximal level of economic and social usefulness of the patient.

Dr. Hines will discuss the specific facilities which are properly termed rehabilitation services. It is for me, therefore, to outline briefly the areas of care which are not usually thought of as rehabilitation services but which, we all admit, play an integral role in the total medical problem of the patient and hence his total plan for rehabilitation.

We in Connecticut are fortunate that we can talk about the provision of services for the aging person and have specific services to hold up as examples. Few states have recognized in a material way the need for using all of the services which I will outline in the brief time allotted.

At the outset there are two principal points which must be recognized. First, no type of facility and no one group can hope to care for the myriad medical problems which accompany the aging process, and second, the adequate care of the person in advanced years does not require any major upheaval in the way in which medicine is practiced in our State today.

The practicing physician who has the primary

responsibility for caring for the patient at all times is the one on whom any plan for care must be built. Making accessible to the practicing physician both adjunctive services and up-to-date knowledge about facilities available to his patients is a responsibility to be borne by both governmental and voluntary agencies. At the early stages of a movement such as that in which we now find ourselves, we must provide every opportunity for both undergraduate and postgraduate education.

We must not only inform the physician about what can be utilized for his patient, but we must place at his disposal the skills of professionally trained persons who can follow him into the patient's own home and through organized home care programs bring into being an additional resource. Through such a resource, modern medical care can be given in familiar surroundings without breaking family ties or substituting strangers for the personal attention of blood relatives. Because our State agencies have had the benefit of enlightened understanding and support from our citizens and their elected representatives, funds to aid in such ventures can be made available through the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm.

This Commission can also bring to localities wishing help in developing such programs the skills of specially trained persons employed by the Public Health Service, one of whom so kindly consented to be with us at yesterday's session.

By thus strengthening services to the family, the necessary institutions for specialized services can be used most economically and to the advantage of more citizens of our State. When we speak of specialized facilities we mean not only centers such as this one at Rocky Hill, the Woodruff unit about to open, and institutions like the New Britain Memorial Hospital, where rehabilitation services are offered. We



also mean that the general hospitals, and our private chronic and convalescent hospitals, have very definite roles to play, depending on the stage of the patient's illness.

We are concerned not only with physical ills but also with the psychological problems of the aging process. All the facilities mentioned will be playing more of a role in the care of individuals heretofore committed unnecessarily to mental hospitals. All of us are most hopeful that the new Mental Health Commission, working with the Commission for the Chronically Ill, can develop the most appropriate roles for these agencies to play.

This example of interrelationship between agencies points up probably the greatest single need in the field of care of the person in later maturity: the need for better integration of services so that a total plan can be developed for an individual and the appropriate resources marshalled at the most appropriate time. In meeting this need for integration to avoid any waste in our very precious resources we will give better service to more people, with the least expenditure of time and effort.

Integration is not something that just happens; it is the result of working relationships between all agencies and individuals concerned with any aspect of the problem. This conference represents a step forward in the interchange of ideas and information, and thus the integration of services in our State. All of us here can contribute much toward the achievement of functional integration in our own communities so that comprehensive services will be a reality, rather than a need, for our older citizens.

#### REHABILITATION OF THE AGED

Thomas F. Hines, M.D., *New Haven*

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Dr. Shindell has mentioned the close correlation between the groups on Care and Rehabilitation of the Aged. Indeed, the concept of rehabilitation is an integral and essential one in all discussions of the problems of the aging.

I think we should restate in this summary first of all our definition of rehabilitation as applied to medicine. We note the dictionary definition of the word to be: Making an individual a useful member of society again. We use this definition in its broad-

est sense to include all medical disabilities—either physical or mental—which have set the patient apart from society in some way.

We might embody this concept again in a case history. A male patient in this case who suffered a stroke of the right side of his body with loss of speech. Obviously, his first need was acute emergency care. Because he remained unconscious and vital signs deteriorated he was admitted to the hospital. Oxygen and appropriate acute care brought him into the convalescent phase where physical therapy was begun to maintain his joint motion. Social survey was done and present and future problems discussed with his family. Financial assistance from an agency was obtained. Speech therapy was begun and continued. Psychiatric advice was sought for emotional problems precipitated by family and financial difficulties. The patient regained enough strength in hip and knee to walk very adequately with a short leg brace and cane. No function returned to the arm and severe speech involvement continued. Fortunately, he could be taught writing with his left hand and had fairly complete expression of ideas. Future occupation is being discussed and because he was a skilled worker we anticipate that he will probably be able to return to some aspect of his previous line of work, with some specially adapted equipment in a less competitive atmosphere than he previously encountered.

In such a difficult case, I believe we can demonstrate best the concepts of necessary care in medical rehabilitation. We can also appreciate, as Dr. Shindell mentioned, that this can never be accomplished in its entirety by any single individual. All groups and specialties in medicine have a stake in rehabilitation and every skill is needed in many of these cases.

We should note also the increasing need for rehabilitation in the aging population. If we first look at some figures we see that by Metropolitan Life Insurance statistics the life expectancy of industrial workers doubled between 1880 and 1940, from 34 to 68 years. We now have approximately 13,000,000 people 65 years of age or over. By 1975 it is estimated that 22-23 million will be in this category. In Connecticut it was stated that 1 in 10 is now 65 years or more.

With increasing age comes increasing incidence of the chronic disabling or degenerative diseases—the shocks or strokes, cardiac diseases, diseases of the blood vessels leading to amputations, degenerative

diseases of the central nervous system, the complications of metabolic disorders as diabetes. It would seem evident then that an increasing number of physical facilities and personnel will be needed to keep pace with the increasing need for rehabilitation services.

Now what can we offer specifically in terms of facilities in Connecticut? For inpatient rehabilitation services we have such installations as Rocky Hill and the New Britain Memorial Hospital, and the soon to be opened Woodruff Center in New Haven under the Commission for Chronic Illness, the Rehabilitation Unit at the Grace-New Haven Community Hospital, where complete rehabilitation teams are in operation or will be in the near future. We have, in my experience, the interest of some other general hospitals in setting up inpatient rehabilitation beds as needed, where the shorter term patient can be cared for. We have growing outpatient facilities exemplified by the Hartford, Stamford and Bridgeport Rehabilitation Centers, the outpatient clinics at Hartford Hospital, New Haven Hospital, Waterbury Hospital; the growing number of general hospitals making a start by opening departments of physical therapy. We have the nuclei of home treatment programs in the Mobile Arthritis Treatment Unit in New Haven, and a similar unit, probably soon to begin in another area; the beginning of a combined effort by the Hartford Rehabilitation Center and the V.N.A. to afford better home care; the V.N.A. at Waterbury, which has at present one physical therapist for home treatment. Time prohibits a more complete listing, and we have not touched on facilities dealing with other phases of rehabilitation, such as the mentally ill or blind. We are fortunate to have in Connecticut such facilities already in operation which can be the building stones for a more extensive program in the future, to keep pace with a growing demand.

In closing, we will list some of the needs for the future. Of prime importance is the problem of education, both for the medical and ancillary groups, as well as the public in general. We must begin at the medical school level, teaching rehabilitation as any other phase of medicine. An attempt to get more practicing physicians aware of the benefits of these concepts, probably through the local medical societies, can be made. Future meetings such as this one just completed will help to keep us all better informed. The need for increasing facilities and personnel has previously been mentioned.

A very important need is the dissemination of information, as to where rehabilitation services can be obtained, for all of us working in this field. A complete compilation of much information could then be sent to all individuals interested and involved in any phase of care and rehabilitation. A second method might be the setting up of a small central information service, properly publicized, from which point the above mentioned information could be disseminated and rapid and proper referrals made.

We believe then that a good beginning has been made in Connecticut in understanding the future problems to be faced in rehabilitation of the aging population. If the above needs are accomplished, we believe we can better determine and keep pace with the growing needs for these services.

#### CHRONIC ILLNESSES OF OLDER PEOPLE

Alfred L. Burgdorf, M.D., *Hartford*

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The Author. *Director of Health, Hartford Health Department*

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Desirable for this discussion might well be:

1. A definition of chronic illness.
2. A definition of older people.
3. An estimate of the number of people in that "older people" group.
4. Data on the prevalence of chronic illness in the group.

The panel assumed that this group was well acquainted with the many suggested definitions of chronic disease, and that everyone knew what was meant by older people. Perhaps the best definition of the "aged" is still "someone who is ten years older than you." This at least introduces a highly dynamic element of relativity.

Since no new definition for chronic illness was offered, it is safe to report for the record those elements that have gone into previously published definitions:

Length of illness—anywhere from 3 months or more.

Presence of disability—1 week or more.

Type of morbidity involved—excepting tuberculosis and mental disease.

The panel did document Connecticut's population shifts from 1910 to 1954 and this was helpful in



estimating the number of "older people" in the aged group.

The fact that the best figures on prevalence of chronic illnesses of older people in Connecticut is still "The National Health Survey" twenty years ago points up the great need for more current facts in this field. I shall not repeat those statistical comments except to say that they adequately bear out the need for continuing concern in this field.

Once having established certain base lines, the panel discussed factors that must be taken into consideration by the private physician in dealing with people who in moving along the chronological trail must make certain adjustments to their environment. They stressed the need of seeing the person or patient in a true perspective in his particular individual setting, realizing that any one of many factors might be major for the person in question, be it: gainful employment, recreational patterns, self care, changed dietary habits, retirement, changed physiological responses, family relationships, etc.

Basic to all these individual considerations was the need to establish or maintain "meaningfulness of life."

To this reporter that theme recurred throughout the conference—get away from categorizing people and help them retain the dignity of living. The "family council of war" to retain that dignity seemed like a good suggestion when personal reorientation to family and community living approached a crisis—avoidance of institutionalizing patients as long as practicable.

The last speaker on the panel tied this theme in by pointing out that the two preceding epochs in public health—the era of sanitation and the era of communicable diseases—were eras of mass action which could accomplish great things without great individual effort. In the new era of chronic disease, individual action is essential if we are to make the strides in public health that we made in the past.

#### HEALTH MAINTENANCE FOR THE AGED

Harold S. Barrett, M.D., *Hartford*

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After consideration of the case of Mrs. "X," and a review of the common chronic conditions affecting older people, the conference turned its attention to the healthy oldster and his efforts to maintain this

status. While no specific statistics were presented, by inference from population data and chronic disease prevalence rates presented by the panel on chronic illnesses of older people, it may be assumed that the healthy individual represents the numerical majority. This is indeed a fortunate circumstance. In this group preventive medicine can act constructively to avoid the costs of chronic disease care and rehabilitation, to minimize human suffering and to promote full health and its benefits, enjoyment and productivity. With humility the panel acknowledged that a total triumph of this kind is impossible, for a function of the physician in the periodic physical examination was stated to be to detect latent disease or its precursors and to advise the patient as to its correction or control.

#### HEALTH INVENTORY

This periodic physical examination at least every year for the healthy older person was endorsed as a tool of health maintenance and health education, the value of which to the individual, his family and the community was accentuated with increasing age. Furthermore, said the panel, it should be undertaken by the doctor in the spirit of friendship which would evoke a full and detailed medical history. Its greatest gift to the patient was reassurance. Interpretation of the physiological changes associated with aging, counseling to fit activities to capacities, guiding vocations into avocations, particularly of a "service to others" nature, and destroying health fetishes, were emphasized as functions of this tool. Laboratory aids of either a screening or definite nature were considered of some use, but the time of an hour to an hour and one-half in a face-to-face contact was emphasized as necessary. With reluctance the panel noted that there was no immediate pat solution to this time factor.

#### FOOD

Nutrition does or does not change with age depending on the perspective employed for consideration, said the panel. All people, regardless of age, require energy foods, proteins, minerals and vitamins, since these are essential foods. The amounts required may be different, dependent on the energy requirements and decreased utilization with age, the latter being the result of an invisible physiological decrease in digestive secretions. It was emphasized that personal interest is necessary for adequate and proper nutrition. Lessened activity with increasing age means lowered energy requirements and there-

fore less dietary fat. Lowered utilization of the so-called protective foods may require a relatively higher proportion of protein, and of minerals, particularly calcium. Dental deficiencies may necessitate bland foods. Milk and cottage cheese were mentioned as good economical sources of protein and minerals, especially calcium, in a bland form without roughage, and simultaneously noted as distasteful to many oldsters. Fad foods and diets were condemned. The general principle stressed was to improve food habits rather than take dietary supplements.

#### HOUSING

Familiarity with environment results in peace of mind. This principle ran through the discussion of housing for older people. The panel felt that living arrangements were a matter of individual choice, that oldsters preserved their independence and privacy by living alone, that they should be a part of the community and not housed in unfamiliar special projects. Accidents in the home were recognized as a preventable hazard. The statement on housing distributed to the conference was commended as both practical and in keeping with these principles. Finally it was recognized that some form of housing supervision (by physician, family, or authority) was required to protect health (accident prevention) and assure public safety.

#### EMOTIONAL ADJUSTMENTS

In consideration of the mental and emotional aspects of aging, the conference was advised that there were multiple perspectives to aging. The panel warned against coining new words and pompousness in presentation. In many ways old people are not different from young people. Honesty should force recognition of the fact that a more aged 25 does not become by definition a geriatric problem when he reaches the chronological milestone of 65, but remains the uninteresting, colorless individual which he has been during the preceding 40 years. Individual differences and interpersonal relationships were stressed. Old people are not a specific mental and emotional problem group suddenly arising in this contemporary civilization, but have existed through time, and are only more numerous now.

#### COMMENT

In summarizing any panel discussion it is worth considering what the participants did not say, since in the brief time available for presentation, omissions may be significant indications of thought. This panel

did not define "aging" or "old." The subcommittee on planning for health maintenance did struggle with this issue. It was found that the median age of Connecticut residents in the 1950 census was 32.7 years. By simple classification, below that age a person is young, over it he is old! The committee suggested that the conference might well consider people over this age as its subject material, since physiologically the process of aging accelerates in these later years, and since the socially accepted age of retirement is well above this figure. Health maintenance, always important, assumes greater significance in these later years.

Running through the discussion of all members of the panel was one common thread of thought: This is a personal and individual matter. The panel did not formalize a statement of this fact, but it appears obvious that any plan, program or action taken must be based on the individual and his participation.

#### CONCLUSIONS

The periodic personal health inventory conducted on a friendly reassuring basis is a sound approach to health maintenance. Nutrition for older persons consists primarily of developing good personal food habits. Housing is a matter of individual choice which should be in a familiar environment, safe from accident hazards insofar as it is possible to make it so. Young people may have more difficulty adjusting to the problems of older people than oldsters themselves. Health maintenance is a continuing individual process which constantly requires personal participation. Personal health is both a goal and a reward in itself, and there remains a hopeful outlook epitomized in the statement made at any chronological age: "We're all going to be old sometime."

#### EDUCATION AND RECREATION FOR THE AGED

Alan E. Hugg, PH.D., *Hartford*

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The helpful statements made by David King and William Rowe have provided a useful background of information on what is now being done in educational services for the older residents of our communities and they have opened up challenging vistas of service for those who are interested in the welfare and continued social usefulness of our older citizens.

In our State there are 29 higher educational insti-



tutions and 60 local public school systems that are rendering adult education services to the adults of our State. It appears that a very small number of these colleges and public school systems have developed educational programs and services focussed specifically on the problem of later maturity. The University of Connecticut has sponsored and published some useful social research on the problems of older adults in rural communities of our State. Hillyer College in Hartford recently sponsored an Institute on Life in Later Maturity directed primarily at those who are professionally concerned with developing programs and services for the older adult. In at least two cities, Hartford and New Haven, the public school adult education program has offered a series of presentations on the problems of the older adult as he confronts retirement with its economic, social, psychological, health and recreational problems. In a few other cities the public school adult education directors have rendered helpful service in working closely with other community agencies in community planning of services for the older citizen.

Unfortunately we do not yet have a very adequate picture of the services being rendered by the public recreation agencies of the State and by the many private and voluntary agencies. Examples of these valuable services are the activities for older adults sponsored by the YMCA industrial recreation council in Bridgeport and the exhibit of the hobbies and crafts of older residents sponsored by the recreation department in Hartford, and the many "golden age" groups sponsored by a variety of different agencies in several cities.

In addition to these services specifically focussed at the older citizen there are, of course, a large number of college extension courses, public school adult education classes, and adult activities sponsored by voluntary groups and agencies, and numerous recreation agencies which serve adults in general, including a substantial number of older adults.

These brief indications of the scope of present education services for the older adult have helped to clarify some of the directions that we in Connecticut should begin to move in strengthening these services.

1. We need to strengthen our ability to attract and to serve the older adult in the regular adult education and recreation program of the various public and private agencies in our State. This is partly a

problem of publicity, but is also a problem of program method. As we improve our competence in the process of program development and in educational method with adults not only will the older adults benefit but the total adult constituency will be served better.

2. There is evidence that special skills, sensitivities and attitudes are necessary in working with groups of older adults in social educational and recreational activities. Undoubtedly the greatest values are found in programs in which the older people themselves assume responsibility for determining the nature of the program and for administering it. These group work skills combined with the special competencies and information in the "developmental needs" of the older adult are greatly needed by the volunteer and paid workers concerned with this age group in both private and public agencies. Training courses of this type would be a useful service in college extension courses or in public school adult education programs.

3. Another educational service for which increasing need is apparent is the systematic presentation of information on the problems of later maturity for those citizens who are beginning to be confronted with questions and doubts concerning retirement and its financial, social, health, psychological and other implications. Courses and institutes of this type dealing with this subject matter should be offered by many more educational institutions in this State.

4. The need of business and industry to assist their employees to prepare for retirement is one in which educational agencies should be helpful. Fraternal organizations and membership organizations of many different types are increasingly interested in providing educational services of adult type for their members. It is to be expected that as our educational agencies develop competencies in providing consultant services of this type to organizations that want to set up an educational program of their own, they will be called on more frequently for assistance in planning these educational programs.

5. It is logical to expect that some of our higher educational institutions will in the near future develop services and staff competencies in the field of gerontology and begin to give the type of educational leadership that is at present coming out of a few universities in other parts of the country. Lead-

ership with its necessary implication in terms of staff, money and facilities in the area of the social, psychological and educational aspects of gerontology is at the present time in our State by no means commensurate with the magnitude of the problem, and the unique needs so clearly apparent in the demographic and industrial characteristics of our State.

Strengthening our educational services in these ways will call for a willingness to readapt these services into new forms of usefulness, and a new sense of urgency in fulfilling our responsibilities to our older citizens.

COMMUNITY PLANS AND RETIREMENT

Milton L. Shurr, *New Haven*

The Author. *Council of Social Agencies, New Haven*

Dr. Loomis in her discussion on community plans as well as our distinguished panel presentation on industry have, I believe, indicated the growing maturity on the part of industry and our society in recognition of our concern with a long neglected portion of our population. Miss Loomis discussed the increasing concern of communities in planning for services and the coordination of resources. She stressed the need for social contacts, awareness and utilization of community resources, decent housing and opportunity to be as active or as leisurely as they choose.

Effective work towards objectives is a responsibility on the part of Federal, State, local communities and the individual. The federal government can provide (1) for a continuation of leadership such as organization of conferences and (2) the stimulation and integration of research and acting as a world-wide clearing house for the local community on what is being done and planned. The State government is responsible for clarification and enforcement of standards and improvement in personnel. Certainly this is needed in areas of nursing services and rehabilitation. The individual older person also has a responsibility to learn, to accept, to adjust in finding his newer riches when world patterns and people are in a state of change.

The reported results of the questionnaires indicate that about a dozen communities in Connecticut are each developing, along their own local patterns, programs for older people. A number of them are

doing their planning under the auspices of Councils of Social Agencies, others under auspices of groups of agencies, churches and civic groups. We need to stimulate and develop more opportunities to enable the older members of the community to actively participate in the planning and operation of community programs. Dr. Loomis suggests six points communities need to consider:

1. Information Centers—with connection to counseling services.
2. Centers and clubs for the older citizen.
3. Well organized and representative committee to plan and to implement this planning in active services.
4. Periodic review by the central committee of the entire community programs.
5. Each organization should review its own program for the older person.
6. Publicity, formal and informal—to give recognition and interpretation to services and programs.

All programs must be developed with a view to local resources and problems.

PANEL ON RETIREMENT PLANS IN INDUSTRY

Moderator: Archibald Williams, American Hardware Co., New Britain, Connecticut.

Speakers: J. E. Curran, Esso-Standard Co., New York; C. T. Nolan, Sargent & Co., New Haven; Arnold Freas, Jr., Ensign-Bickford Co., Simsbury; Michael Holahan, Pitney-Bowes Co., Stamford.

There is an increasing concern on the part of industry on behalf of their older employees and assisting them in their planning for their retirement. We heard about the program of Esso-Standard Co. as discussed by Mr. J. E. Curran, which was one of the first in the field and from four Connecticut concerns—Pitney-Bowes of Stamford, Sargent and Co. of New Haven, American Hardware of New Britain and Ensign-Bickford of Simsbury.

From these statements a number of points were made which are of interest to us. Retirement programs need to be geared to the local programs, to industry, and to the needs of the individual. From these discussions the planning committee recommends four points for a program in industry.

1. A voluntary program for the older prospective annuitant giving him a view of what he will face and stimulate organized thinking towards suitable plans. Such a program is conducted at Esso-Standard Co. on a voluntary basis and covers such items as:



- a. What is retirement?
- b. Financial aspects.
- c. Planning.
- d. Medical aspects.
- e. Round table and discussion, including former retired employees discussing their experiences.

## 2. Counseling.

Counseling or friendly consultation with a skilled person aids the older worker to adjust within the plant and also effects for constructive planning for retirement. Sargent & Co. gave an excellent example of the effectiveness of this where they have no compulsory age.

## 3. Medical evaluation.

This together with good counseling can lend to effective placement of older persons on jobs and

positions where their skills and experience are decided assets if their physical capacities and interests warrant continued employment. Ensign-Bickford gave an example of a medical program.

## 4. Follow-up.

Many plants as Pitney-Bowes, Esso-Standard and Sargent & Co. had some continuing relationship to the older employee. These ranged from participation in annual parties, receiving publications, to permits to visit plant at any time and consultation on problems of retirement and financial aid from Employees Fund when necessary.

The common denominators in all of these were the medical, social and production evaluation of the employee and the flexibility of plans, which were voluntary and the democratic approach and preservation of the dignity of the employee.

# MONKEY ISLAND

LEO LITTER, M.D., *Hartford*

WITH rising enthusiasm we reached Humacao Playa in southeastern Puerto Rico. About a mile off shore rose the tiny island of Santiago—more commonly known as Monkey Island where the School of Tropical Medicine maintain a monkey colony for experimental purposes. The colony established in 1938, is being sponsored by Columbia University for the purpose of raising conditioned animals of a known history for medical research.

We walked along the narrow catwalk of a long pier, the planks of which had been removed during the hurricane season. The framework over which a few boards remained served as a gangway. We signaled to Mr. Tomilin who sent out a rowboat to fetch us. With powerful strokes, and in less than half an hour, a native boy rowed our party across the relatively calm but shark-infested sea.

Approaching the island one seemed to be entering a new world. The scene might have come from "Robinson Crusoe." Fringing the shore were cocoa-

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The Author. *Assistant in Epidemiology, McCook Memorial Hospital, Hartford; Assistant in Pediatrics, Mt. Sinai Hospital, Hartford*

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## SUMMARY

A visit is described to Monkey Island home of Columbia University's School of Tropical Medicine monkey colony. These monkeys are used for experimental purposes. The clientele of the colony is described, together with their habits, and a description of the keeper of the colony is included.

nut trees, devoid of fruit, however. Atop a small hill stood a sturdy little house built of wood.

We landed at a little clearing in the cocoanut grove and started walking along a narrow winding path towards Tomilin's domicile. Arriving at the top, we paused to catch our breath. A huge, weather beaten man wearing shorts, jersey and sneakers soon

appeared at the threshold. Silently he gazed down upon us then, without warning bellowed, "Who the h— are these people?" The fair lady in our party summoning up courage, approached our towering host and smilingly apologized for our late arrival—we had been invited. Later we presented Tomilin with a case of beer. He frowned at it and roared, "What the h— do you think I am, a baby?"



MONKEY ISLAND WITH PUERTO RICO IN BACKGROUND

With its 35 acres, the island, shaped like a dumb-bell, provides a haven for 450 British Indian rhesus monkeys who live natural lives unhampered by cage or other restrictions.

"Trying to grow anything here is a fruitless effort," Tomilin said. "Those monkeys followed right along behind me and either broke off the freshly planted shoots or picked out the seeds and threw them around." "Cocoanuts don't stand a chance of getting any farther than the bud stage," he explained. "But as soon as the palms bear a new growth of buds the monkeys are up and at them twisting them from their stems and throwing them to the ground or at each other."

All of which meant that all sustenance for these destructive creatures would have to be imported from the mainland. The chief staple is sweet potato. Once a week bananas brighten the menu. A food concentrate, developed by Tomilin himself, provides the primates with vital animal proteins and mineral salt, and oyster shell flour.

The monkey colony has divided itself into six tribes, the largest comprising 150 members. Each group has a leader or "president," as Tomilin prefers to call him, who elects himself by beating every other male in the group. The tribal chieftain can be

recognized by his huge size, his cauliflower ears and as the only one in his group with his tail in the air.

Then there are the bachelor clubs whose members spend all their time fighting one another. Often Tomilin finds, lying on his back in a thicket of shrubbery, the corpse of a bachelor stiff as a board with extremities flexed in a death caused by tetanus infection resulting from the wounds of battle.

What the monkeys do not eat right away they store in inner pouches around the gullet. The pouch distinguishes the Indian and African monkey from the American variety which does not have them. An hour after breakfast the monkey colony "retires into the bush for a siesta," as Tomilin puts it. They emerge late in the afternoon.



MONKEY FAMILY

Family life does not exist, a female bearing a child of unknown fatherhood about once a year. Contrary to common belief, the males do not fight over the females for evidently there are plenty to go around.

Mortality rate on the island is surprisingly low, there being about one death a month. Tetanus from wounds of battle is common. Death has no particular significance to a monkey and when it comes the dead body is completely ignored. One exception to this is the death of a baby; the mother carries the body with her until it has completely disintegrated.

We witnessed a fascinating sight, scores of mothers scampering about carrying their young on their backs. They resembled Indians crouching low upon their swiftly moving ponies. The ears of many mothers and babies were torn and bleeding as a result of combat. One mother had been carrying a dead child for the past two days, unable to understand why it did not frolic about like the others. It



had been killed while its mother was engaged in battle. Tomilin had an idea! He threw handfuls of his food concentrate in her vicinity. Immediately the other mothers flocked about her, quickly snatching up the food without taking time off to eat it, but storing it in their pouches in order to get as much as possible before their colleagues would beat them to it. Later they could eat their hard won victuals at leisure. In the scramble for the food the dead child dropped to the ground. Tomilin stooped to pick it up. Immediately the mother shook her clenched fist at him and all the other mothers looked menacingly towards him.

He had to relinquish the dead one. Later he was able to retrieve it by throwing the food sack over it while dumping its contents on the ground in front of the tiny, motionless creature.



FEEDING TIME

In several respects Tomilin's monkeys resemble gypsies. Anthropologists claim that the gypsy originally came from the northern part of India, which is also the source of the primates of Santiago Island. Then again both the nomads and the monkeys are kleptomaniacs.

Monkeys are thieves. They carry off everything which is not tied down, especially small objects. While we were having our lunch on the porch some of them sneaked up and boldly swiped our cake. When we turned around to chase them away, others quickly approached from the other side, also taking their share of our picnic lunch.

Disciplining the monkeys constitutes one of Tomilin's many problems. It ranges from confinement in a stockade to death for the incorrigibles.

The crimes vary from depositing excreta on Tomilin's porch to monkey murder. The spacious, wired stockade housed one prisoner, a bull weighing 24 pounds, whom Tomilin claimed could outbattle Joe Louis. His offense, biting his comrades from ambush! Another mischievous macaque received a bullet in his arm, a casualty which, however, did not put an end to his many misdeeds.

Recently, for some unknown reason, a mother carrying her child was driven from her home by her tribe. Had she remained she would have been slain. She swam across the lagoon which divides the island almost in two, hoping to find shelter at the other end in the domain of another tribe. However, when she tried to climb ashore she was met by unfriendly members of the neighboring tribe who forced her back into the lagoon. Here was the poor mother struggling in the water with her youngster on her shoulder.

Her piercing cries for help brought Tomilin rushing to the scene. The rescue was soon effected. Tomilin can tell by the sound of a battle cry whether it is merely a skirmish or one of serious proportions.

The monkeys have a language of their own which we humans are unable to understand. However the Ruler of Santiago Island evidently comprehends a good deal of their gabbling. As twilight fell scores of young ones were frolicking in the tree tops. Amidst this gaiety a loud chattering was heard. As I turned to Tomilin for an explanation he murmured, "That is merely the mothers reprimanding their young for not going to sleep." Some of the simians understand such simple commands as "Open your mouth," "Stop it" and "Get out of here."

The Ruler of Monkey Island, Mike Tomilin, was born in Siberia 45 years ago. Because of his deep knowledge of psychology and of primates, he was granted his present position. He is a big, rugged individual with keen, searching eyes and fine facial features. He is about six feet three and weighs about 220 pounds. To the question, "Can you tell the monkeys apart," he replied, "I don't remember people—they are below my dignity—but monkeys, they are on my intellectual level." Although a White Russian, he enjoys teasing the nobility who occasionally drop in to see his monkey colony.

In not a few respects he resembles "Tarzan." Not long ago he caught with his bare hands a five foot shark. After we had eaten our lunch he singled out

the lady member of our party and said, "Now you will help my wife with the dishes."

On the mainland he has been nicknamed "El Ruso" (The Russian). He is extremely popular and beloved by all. With funds dwindling he is obliged to spend much time searching for food for his primates. He is a past master at bargaining. Though he is compelled to do it in order to balance his budget, he dislikes bargaining immensely. He maintains that whittling down the price often makes the poor jibaros with whom he deals do without a pound of rice or two that they might have bought had he not cut down their prices.

He never gives a begger a penny. Instead he directs them to a certain bakery where they may obtain a little bread for which he pays. Smilingly he remarks that he may run for mayor of Humacao since all the jibaros and bums are for him.

Until now Columbia University has been forwarding the necessary funds for the Colony's upkeep, but that institution has now discontinued its good work. Tomilin is worrying greatly and is running himself ragged trying to scrape up the necessary funds to keep the colony going. He has been offered several jobs elsewhere, but he is so attached to his monkeys that he cannot bear to part from them or leave them to starve. He has been with them for five years. Without Tomilin the island would lose a great deal of its charm and lure.

The silhouette of the monkeys in the twilight swinging from trees was an unforgettable sight, and the last one we saw as we departed from the primate kingdom.

The strong current made the return crossing longer. Night was soon upon us. The oars dipping into the calm sea caused a soft green phosphorescence.

To visit the monkey colony we had traveled over 150 miles, but it was well worth it. Just to see and hear Mr. Tomilin talk had been a great treat.

As we drove homeward someone asked me why I looked so sad. I was preoccupied with Tomilin's biggest problem, how to feed the simians now that financial help from the sponsors would no longer be available. It would be a great shame and loss to both the medical profession and humanity were that monkey colony allowed to disintegrate; for it is the only one of its kind in the world. The monkeys of Santiago Island have been used by research workers throughout the United States in an endeavor to find cures for such diseases as infantile paralysis, schistosomiasis and many others. They have also been the subjects of many an interesting psychological study. Tomilin believes that they may also be used to further our knowledge of the venereal disease, especially that of granuloma inguinale.

#### ADDENDUM

Contents of letter dated August 19, 1953, from the Dean's office: University of Puerto Rico, School of Medicine, School of Tropical Medicine, San Juan, Puerto Rico.

"The colony of monkeys has been continued under the auspices of the School of Medicine, although its size has been somewhat reduced owing to our extensive use of its monkeys for experimental purposes. In the past two years, we have been using them faster than reproduction has occurred, so that we will have to slow down somewhat the rate of usage.

"We are operating the colony from a long range point of view by sending a truck-load of foods (vegetables and fruits) once per week and the maintenance of labor as caretaker on the island. Mr. Tomilin left the island several years ago."



29th CONNECTICUT CLINICAL CONGRESS  
of the  
CONNECTICUT STATE MEDICAL SOCIETY  
and the  
YALE UNIVERSITY SCHOOL OF MEDICINE

---

GRACE-NEW HAVEN COMMUNITY HOSPITAL AND THE YALE SCHOOL OF MEDICINE,  
NEW HAVEN

September 15, 16, 1954

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The 1954 Clinical Congress will be concentrated in two days and all of the meetings will be held at the New Haven Hospital and the Yale School of Medicine.

Three sessions will be held simultaneously in three different meeting places giving a broad selection of topics. Material in the fields of vascular diseases; psychiatry; drug and alcohol addiction; pediatrics; general medicine; general, special and traumatic surgery; and other related subjects will be presented.

Registration for members of the Society will be \$3 and nonmembers \$4. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be served on both days by the New Haven Hospital.

**PRELIMINARY PROGRAM**  
**29th CONNECTICUT CLINICAL CONGRESS**  
**WEDNESDAY, SEPTEMBER 15, 1954**

**MORNING SESSIONS**

TIME	BRADY AUDITORIUM	FARNUM AMPHITHEATER	FITKIN AMPHITHEATER
9:30	REGISTRATION	REGISTRATION	REGISTRATION
	Bliss B. Clark, <i>New Britain</i> , presiding _____	Hugh K. Miller, <i>Stanford</i> presiding _____	Benjamin V. White, <i>Hartford</i> , presiding _____
10:00	THE SURGICAL MANAGEMENT OF VARICOSE VEINS, VARICOSE ULCERS AND THE POST PHLEBITIC LEG Charles V. Menendez, <i>Brookline</i>	CERVICAL PATHOLOGY IN STERILITY PROBLEMS Lee Buxton, <i>New Haven</i>	PRINCIPLES OF ANTIBIOTIC THERAPY— CHOICE OF TREATMENT Paul B. Beeson, <i>New Haven</i>
10:45	GASTROINTESTINAL COMPLICATIONS OF ANTIBIOTIC THERAPY Chester W. Fairlie, <i>Hartford</i>	THE USE OF PITUITARY EXTRACT IN THE CONDUCT OF LABOR D. Anthony D'Esopo, <i>New York</i>	SOME PRINCIPLES OF ANTIBIOTIC THERAPY —THE CLINICAL RESPONSE Ivan L. Bennett, Jr., <i>Baltimore</i>
11:30	PEDIATRIC SURGERY Nicholas M. Stahl, <i>Boston</i>	ENDOCRINE ASPECTS OF INFERTILITY Somers Hayes Sturgis, <i>Boston</i>	DRUG RESISTANCE AND ITS CLINICAL IMPLICATIONS Harry Eagle, <i>Bethesda</i>

12:30 LUNCHEON, Cafeteria, Memorial Unit

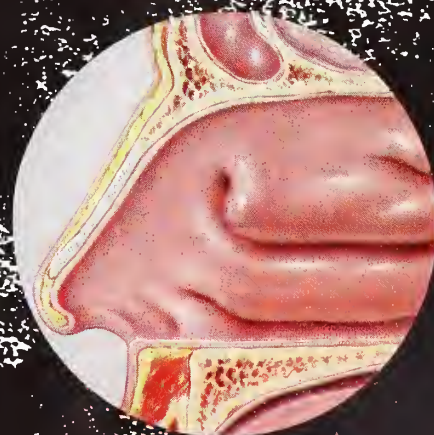
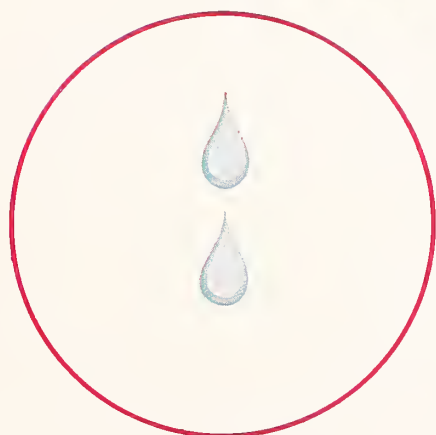


## AFTERNOON SESSIONS

TIME	BRADY AUDITORIUM	FARNUM AMPHITHEATER	FITKIN AMPHITHEATER
	Gustaf E. Lindskog, <i>New Haven</i> , presiding —	Oliver L. Stringfield, <i>Stamford</i> , presiding —	Gideon K. deForest, <i>New Haven</i> , presiding —
2:00	CARDIAC ARREST, INCLUDING AN APPRAISAL OF THE MECHANICAL DEVICES FOR TREAT- MENT Julian Johnson, <i>Philadelphia</i>	ERYTHROBLASTOSIS AND JAUNDICE IN INFANCY David Yi-Yung Hsia, <i>Boston</i>	THE DIFFERENTIAL DIAGNOSIS OF JOINT PAINS Marian W. Ropes, <i>Winchester</i>
2:45	SURGERY OF THE URETER, PLANNED AND ACCIDENTAL Willet F. Whitmore, Jr., <i>New York</i>	BEHAVIOR PROBLEMS IN ADOLESCENCE Felix P. Heald, <i>Boston</i>	OBSERVATIONS REGARDING NON HORMONE THERAPY FOR ARTHRITIS Richard H. Freyberg, <i>New York</i>
3:30	THE SURGICAL TREATMENT OF MITRAL STENOSIS William W. L. Glenn, <i>New Haven</i>	INFECTIOUS DISEASES IN CHILDHOOD William L. Bradford, <i>Rochester</i>	THE MANAGEMENT OF RHEUMATOID ARTHRITIS Charles Ragan, <i>New York</i>

2 drops  
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**new  
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*Certain observations are particularly worth noting ...* →

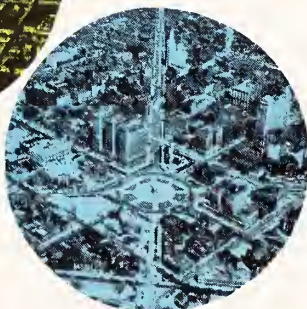


(PHOTOGRAPHS FROM A STUDY CONDUCTED BY GIBA)



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periphery  
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Priscoline® hydrochloride (tolazoline hydrochloride CIBA)



**BILATERAL  
ARTERIOSCLEROTIC  
ULCERATION** in patient age 65.

At start of Priscoline therapy;  
ulcer, right leg,  $1\frac{3}{4}'' \times 1\frac{1}{4}''$ ;  
ulcer, left leg,  $\frac{1}{2}'' \times \frac{1}{2}''$ .  
With oral Priscoline, 25 mg. four  
times daily for one week  
and 25 mg. every three hours  
thereafter, there was marked  
improvement in 2 weeks  
and healing within 6 weeks.  
No other medication given.



**HYPERTENSIVE ISCHEMIC  
ULCER** of right leg in patient  
age 65. Ulceration refractory to  
treatment for 9 months, with  
patient complaining of severe pain.  
Treated with oral Priscoline,  
50 mg. four times daily for four  
days and 50 mg. every four  
hours thereafter. Healing began  
with onset of Priscoline therapy  
and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA  
BY COURTESY OF R. I. LOWENBERG, M.D.,  
CONSULTANT IN VASCULAR SURGERY,  
CONNECTICUT STATE HOSPITAL,  
MIDDLETOWN, CONNECTICUT.

C I B A

**PRELIMINARY PROGRAM**  
**29th CONNECTICUT CLINICAL CONGRESS**  
**THURSDAY, SEPTEMBER 16, 1954**

**MORNING SESSIONS**

TIME	BRADY AUDITORIUM	FARNUM AMPHITHEATER	FITKIN AMPHITHEATER
9:30	REGISTRATION	REGISTRATION	REGISTRATION
10:00	H. M. Marvin, <i>New Haven</i> , presiding — THE SURGICAL TREATMENT OF INTRACTABLE ANGINA Samuel Alcott Thompson, <i>New York</i>	Samuel D. Kushlan, <i>New Haven</i> , presiding — THE VALUE OF VARIOUS SURGICAL PROCEDURES IN THE TREATMENT OF PEPTIC ULCER John R. Brooks, <i>Boston</i>	Edward J. Ottenheimer, <i>Willimantic</i> , presiding — THYROIDITIS George Crile, Jr., <i>Cleveland</i>
10:45	ACUTE PERICARDITIS Morton G. Brown, <i>Boston</i>	ACUTE UPPER GASTROINTESTINAL BLEEDING AND THE EARLY USE OF DIAGNOSTIC MEASURES Eddy D. Palmer, Lt. Col., USA, <i>Washington, D. C.</i>	INDICATIONS FOR THYROID SURGERY Oliver Cope, <i>Boston</i>
11:30	OPERATIONS FOR CORONARY ARTERY DISEASE Claude S. Beck, <i>Cleveland</i>	PANCREATITIS Marshall K. Bartlett, <i>Boston</i>	RADIOACTIVE IODINE IN THE TREATMENT OF THYROID DISEASE Sidney C. Werner, <i>New York</i>
12:30	LUNCHEON, Cafeteria, Memorial Unit		



## AFTERNOON SESSIONS

TIME	BRADY AUDITORIUM	FARNUM AMPHITHEATER	FITKIN AMPHITHEATER
	Clifford D. Moore, <i>Stamford</i> , presiding —	Luther M. Strayer, <i>Bridgeport</i> , presiding —	Ettore F. Carniglia, <i>Hartford</i> , presiding —
2:00	DIAGNOSIS AND TREATMENT OF OPIATE AND BARBITURATE ADDICTIONS Abraham Wikler, <i>Lexington</i>	TREATMENT OF BURNS Gervase J. Connor, <i>New Haven</i>	CEREBRAL VASCULAR ACCIDENT—THE DIFFERENTIAL DIAGNOSIS H. Houston Merritt, <i>New York</i>
2:45	THE USE OF DISULFIRAM (ANTABUSE) IN THE COMPREHENSIVE THERAPY OF A GROUP OF 1200 ALCOHOLICS Ebbe Curtis Hoff, PH.D., M.D., <i>Richmond</i>	SURGERY ON INJURIES TO THE HAND William H. Frackelton, <i>Milwaukee</i>	THE SYNDROMES OF PROGRESSIVE OCCLU- SION OF CAROTID AND BASILAR ARTERIES Joseph M. Foley, <i>Boston</i>
3:30	THE MEDICAL ASPECTS OF ALCOHOLISM Maurice Victor, <i>Boston</i>	THE MANAGEMENT OF TRAUMATIC SWELLING, OLD AND NEW METHODS Thomas W. Stevenson, <i>New York</i>	DIFFERENTIAL DIAGNOSIS OF SYNCOPE Adrian Ostfeld, <i>New York</i>

# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### The Great Migration

The United States has become the "Promised Land" for physicians from all over the world and conditions are developing which may influence medical service in this country for years to come. The exact number of foreign trained physicians who have settled in America cannot be adequately stated. Some estimates are probably grossly exaggerated, but even the more conservative figures are impressive. The situation as a whole originated in World War II and the political events that were part of it, and there have been many separate but related phases of its course. First, was the exodus of political refugee physicians from Central Europe during the years just preceding the World War and the first few months of hostilities. It is estimated that there were six to ten thousand of them. They had been trained in the schools of Europe during a period of peace and the quality of their education was relatively high and most of them had been continuously engaged in medical practice. Their licensing by the states presented confusing problems, but they were fairly well absorbed into the American scene.

The next was the displaced persons group. These unfortunate people had been banished from their native lands and spent long years in detention camps, often engaged in many occupations other than medicine. At the end of the war came the social problem of what to do with these stateless people and serious and sympathetic efforts were made in several countries, particularly the United States, to relocate them in useful lives and many have been resettled in this country. How many there were is impossible to state for some of them came here in classifications other than physicians, and only after their lives in

this country became stabilized did they identify themselves as doctors of medicine. Four thousand is the figure often quoted. This phase might be thought to be nearly over by now, but it is not, because numbers are still coming into the United States from countries outside the war area, the migrants having first gone to South America or elsewhere and they are now coming in on immigration quotas from those countries. How long this will continue cannot be said.

As things settled down after the war ended in Europe, thousands of physicians returned from military service and found great changes in their homeland economy and pattern of medical practice. Things were not the same. In addition to this, when the medical schools went back into full operation there was a tendency for more and more young men to go into medicine and now all of the countries of Europe, with the exception of Scandinavia, are producing more physicians than be can absorbed. As a result of these two factors there has been for the past five years an increasing number of physicians from European countries coming to America to establish themselves and to make their careers.

The next peculiar and unexpected factor arises from the shortage of interns for American hospitals. It is well known that there are about twice as many internships as there are American graduates. Hospitals realizing that they cannot obtain their house staffs from the pool of recent American graduates have welcomed the arrival of foreign graduates, not only from Europe, but from South America, Asia, Far East and Australia. Many hospitals have quite frankly recruited from abroad and most often these appointments are made without personal interview



or scrutiny of the quality of the applicant's education and sometimes the ability to speak and understand English is not even required. Assistance is given to these physicians in obtaining passport visas and they are brought to this country to serve for a year or two in hospitals that otherwise would be without interns and residents. When their period of service is completed, the hospital that brought them over has little or no interest in their future, and more and more of these imports are quite naturally seeking opportunities to stay in America.

There are two aspects of the problem that have to do with foreign medical education rather than the immigration of foreign physicians. The first of these is the well established trend for native American students, for one reason or another, to go to foreign schools for their medical education and return here thereafter. There are perhaps 2,000 such students in foreign schools at this time, which is equal to about 7 per cent of the enrollment in all American schools. The other is a new development. Graduates of sub-standard American schools and those educated in the peripheral medical cults have found that certain foreign schools admit them with advanced standing and after a brief study in residence they can receive an M.D. degree. They return to America, no longer cultists, but doctors of medicine and seek to be licensed as such.

Dean Rappleye of the College of Physicians and Surgeons of Columbia University has stated that America is unconsciously lapsing into a double standard of medical education which is comparable to the sad state of affairs that existed at the turn of the century before the Flexner Report and the great upheaval of American Medical Education. Another medical educator has stated that a "protective tariff" should be established to safeguard American medical culture and its institutions. It will not be easy for all to agree with these observations, but American medicine and the American people are certainly faced with a major problem. Various solutions have been offered. Ten or more states will not grant licenses to practice to graduates of any foreign schools except Canadian. Several other states require full United States citizenship before licensing. This delays eligibility in most instances for five years after arrival in this country, and settlement in another State with less stringent requirements is sought. One State has revised its laws to require that all graduates of foreign medical schools seeking to obtain a license in that State must first be certified by the National Board of Medical Examiners.

The whole problem has received broad discussion in the Federation of State Medical Examining Boards and lately in the House of Delegates of the American Medical Association. The Board of Trustees of that Association had appointed a special committee under the chairmanship of Dr. Thomas Murdock, and that committee presented a thoughtful report to the House at San Francisco, recommending that a preliminary screening board be established to pass upon the educational qualifications of all foreign school graduates before being examined by State licensing boards. No definite action was taken upon the proposal and it was referred to the Council on Medical Education and Hospitals for further study. The subject is a complex one, but it is hoped that the Council will be prompt in suggesting an effective and practical method to safeguard the American people from the degrading of medical service by inadequately trained physicians.

### The Fable of the Cable Car

What is San Francisco? This we debated over our cups of black coffee and even blacker cigars. The answers varied according to a vivid picture deeply etched in the mind of the individual—the Golden Gate, Nob Hill, Fisherman's Wharf, the Top of the Mark. With the mention of the cable car all were in agreement—Texan and New Englander, the doctor from the wheat fields of Kansas and his counterpart from the bayous of Louisiana—this is San Francisco!

The pathway of the cable car has never been smooth but of late it has been threatened with complete extinction. With this possibility champions have arisen to prevent the disaster but the fight is not ended nor the outcome certain. As we gleefully helped push the little car around at the end of its route we fancied we heard it sigh

"Morituri te salutamus."

If you were wise enough to board one of the cable cars in a certain week in June you found yourself clanging up the vertical hill which is Powell Street, then poised on a level like a bird in flight, resuming the climb to the top, and then you were on Nob Hill. Here stood the Fairmont Hotel, its lobby humming with the voices of smartly attired women, members of the Woman's Auxiliary to the American Medical Association, meeting for their thirty-first annual convention. At the headquarters for the sessions were assembled over 6,000 members, including the officers, committee members and delegates from every part of the United States and from the

Hawaiian Island, guests of the convention and doctors, members of the AMA who were to address the convention sessions.

What does the Auxiliary accomplish? Hearken, ye doctors who persist in maintaining a roadblock in the way of your wives becoming members! Across the broad land Auxiliary members have constantly affiliated themselves with community welfare, legislation, child health, nurse recruitment, health education projects, including placing *Today's Health*, the official publication of the AMA, in schools, libraries, physicians' offices, beauty parlors, and in YMCA reading rooms. From their income they have given \$8,000 to the American Medical Education Foundation and have as individual State Auxiliaries established substantial scholarship funds for future nurses and doctors. From the panels and mutual exchange of ideas the members and delegates have absorbed new points of community service and have returned home richer for the wider horizons of possibilities opening to them.

So the little car climbs and clatters, up hill and down, with its load of merry passengers. May its life expectancy be increased as we look forward to renewed friendships and greater strides in the betterment of human welfare when San Francisco again beckons us in 1958.

## The Importance of Changes in Virulence in Infectious Agents

"What makes this change."

*Shakespeare, Cymbeline*

In every case of infectious disease there are two main factors governing the end result: the infective agent and the infected patient. It is not our purpose to discuss at length the many factors which may reduce the resistance of individuals to infection: inheritance "of the soil," as the French call it, pre-existing acute or chronic disease, malnutrition which may be widespread in certain localities in war or famine, chronic poisoning of various types, physical factors such as dust, and mental disturbances. All may play a role alone or in various combinations.

As a medical student in the late eighties and early nineties of the nineteenth century the author recalls seeing isolated patients with poliomyelitis; always children, always with paralysis. No doubt lack of knowledge of the symptomatology was partly responsible for this experience, for nonparalytic

cases must have occurred. But epidemics of poliomyelitis, first described by Medin in Sweden in 1887, and nowadays occurring every year, were then a rarity in this country. It was not until many years later that the contemporary type of epidemic polio with its not infrequent fatalities, its involvement of the respiratory center, its occurrence in adults, appeared in this country. If the disease had been entirely new here we might have expected a picture of this sort from lack of racial immunity similar to that causing the catastrophic effect of measles when first introduced into remote Pacific islands. But poliomyelitis had doubtless long been known to American physicians. We must therefore assume that something had resulted in stepping up of the virulence of the disease.

Our knowledge of the factors concerned in increasing the virulence of infective agents is still vague. Many years ago Robert Koch submitted evidence that in cholera asiatica a stepping up of the virulence of the spirillum may be necessary to produce an epidemic. In epidemics of plague the virulence of the plague bacillus seems to increase during the course of an outbreak and to recede toward its end. In poliomyelitis the fact that the disease may be produced by several allied strains of the virus, some of which are more virulent than others, suggests that local conditions may possibly lead to the development of new strains. The exact mechanism causing increase in virulence is not, however, clear and several factors may be involved.

These remarks were inspired by a report of J. M. Humphries\* on a small outbreak of chickenpox in eight children between the ages of one and five. In three of them unusual neurological phenomena occurred: absence of corneal and abdominal reflexes, loss of sphincter control, weakness of the legs, convulsions, and difficult respiration. The patient with convulsions, evidently suffering from encephalitis, died. One patient had perianal herpes, and there are many articles in the older literature discussing the relationship between chickenpox and herpes zoster. Dr. Humphries suggests the possibility of stepped-up virulence in the virus of chickenpox in the past year or two. This whole question of changes in virulence is an important one and worthy of continued investigation.

G. B.

\*Jour. Med. Assn. Alabama, 23:198, 1954



## Problems of the Aged

At the recent governors' conference at Lake George, N. Y. Governor John Lodge explained Connecticut's plan for caring for the chronically ill and aged. He told his gubernatorial colleagues that an aggressive program followed over the past three years has increased the bed capacity for such persons from 75 to a newly authorized total of 1,100. This number will be reached when the new Woodruff Center in New Haven is completed.

Connecticut stands well out in the lead in its forward-looking plans for care of its aged and chronically ill. This was brought out recently in the Conference on the Problems of the Aging conducted by the Connecticut Health League at the State Veterans Home and Hospital, Rocky Hill. Elsewhere in this issue will be found a summary of the conclusions and recommendations submitted by committees of the Connecticut Health League at the conference. In succeeding months will appear messages from individuals who deal with specific problems in this field of gerontology.

As physicians we should be proud of the part our State is playing in meeting this new challenge, viz., the care of the aged and chronically ill. The record shows that few states have risen to the occasion and shown the vision in planning for the future that Governor Lodge and the Commission for the Chronically Ill, Aged and Infirm have manifested.

## George W. Kosmak, M.D.

By one of those queer turns of fate the commemorative issue of the *American Journal of Obstetrics and Gynecology* published in honor of its former editor for thirty-three years arrived almost simultaneously with the notice of his death. The passing of George W. Kosmak deserves a word from a friend and fellow state journal editor for Dr. Kosmak also carried on the duties of editor of the *New York State Journal of Medicine* in recent years.

Dr. Kosmak was not only an editor of no mean stature but a leader in his chosen field of obstetrics and gynecology. As the Feitschrift points out, "organizational developments of the last twenty-five years have been of surpassing importance in determining the evolution of obstetrics and gynecology." At the age of eighty Dr. Kosmak kept abreast of the times and was conversant with all these developments. Dr. James Young, editor of *The Journal of*

*Obstetrics and Gynaecology of the British Empire*, in his "Thoughts on Editing a Journal of Obstetrics and Gynecology"\* calls attention to the fact that Dr. Kosmak is known to the obstetrical and gynecological world as the directing genius and in a large part the creator of one of the most influential journals in this specialty at the present time.

His many friends mourn his passing.

\*Amer. Jour. Ob. & Gyn., 68:1, July 1954

## Polio Vaccine Trial Needs Physicians' Aid As It Moves Into Evaluation Phase

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get vaccine.

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of necessary epidemiological information and laboratory specimens are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

## THE PRESIDENT'S PAGE

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### WHY NOT BE FRANK?

**I**n recent years there has been much discussion of the threat of socialized medicine. One argument usually urged against this is that it would destroy the doctor-patient relationship. This is seldom defined, but the term is used in such a way as clearly to imply that it is a cherished, important, almost sacred part of medical practise. There is the further implication that it exists wherever people have free choice of physicians, and that without this intangible factor the medical care of sick people would deteriorate into something too horrible to contemplate.

It is probable that in this country the relationship between doctors and patients is characterized by warmth, respect, friendliness, and mutual confidence in a fairly high percentage of cases. But it would be unrealistic to pretend that all patients, or even a very large majority, cherish toward their doctors the feelings that thoughtful observers would regard as ideal. Unquestionably in many instances the failure to establish a happy and confident relationship is due in large part to the patient, who may be unintelligent, apprehensive, hostile, unable or unwilling to cooperate. But it is clear that the blame cannot be placed entirely on one side. Through many discussions with intelligent but discontented patients I am convinced that one major reason for the failure is to be found in the fact that relatively few doctors ever explain to their patients in clear, nonmedical terms the nature of their illness, what can be done to arrest or cure it, and the general plan of treatment. How often one hears the remark: "My doctor never explains anything to me; he just says I must expect to feel the way I do." What a saddening comment it is when a patient declares that he has consulted many physicians but has never received a clear explanation from any.

In some instances doctors appear to be wholly lacking in the warmth, insight, and sympathy that would lead them to the frank discussions desired by most who consult them. In others they show a curious inability or unwillingness to place themselves on the patient's level, so their brief explanations are given in highly technical language which merely adds confusion to ignorance. But in many cases it is probably to be ascribed to haste, to the pressures that lead many doctors to see more patients than they can treat adequately, and to their failure to realize the extraordinary value of simple, lucid explanations. Aside from diagnostic ability and essential kindness there is probably no quality in a physician for which patients are so grateful as the ability and desire to explain, to answer their anxious questions fully and truthfully, to be as frank as knowledge will permit. From personal experience I know what unhappiness can result from failure to explain; I know also that few things in medical practice bring such deep satisfaction to doctor and patient as frankness. Like mercy, "it is twice blest; it blesseth him that gives and him that takes."

Some doctors persuade patients to enter a hospital for a week, fully intending to continue the hospitalization for a month or longer. One hears frequently of surgeons who have assured patients before operation that they must expect discomfort for one or two weeks afterwards, knowing full well that the discomfort will probably continue for several or many months. This policy of deliberate deception is often based on a desire to avoid alarming the patient. It may be justifiable occasionally in special circumstances, but when adopted routinely it becomes foolish and defeats its purpose. Clearly it must lead to discouragement when the patient finds that he is not doing as well as was expected, or to distrust of the physician who has displayed so little confidence and consideration.

People consult physicians usually because they are sick in body or troubled in mind and spirit. For the most part they come in good faith, confident of receiving help. To deny them the comfort of a truthful and understandable explanation whenever this is possible is to fail in one of the simplest and most important duties of a privileged and honored profession.

H. M. Marvin, M.D.



## THE SECRETARY'S OFFICE

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### Duties of the Committees

#### STANDING COMMITTEES

##### COMMITTEE ON ARRANGEMENTS

Article X, Section 3, Par. 1 of the By-Laws of the Society provides:

The Committee on Arrangements shall be appointed by the component county association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting place of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

*The report of the Committee to Survey the Annual Meeting adopted by the House of Delegates on May 1, 1951 recommended that the chairman and one other member of the Committee on Arrangements, for the meeting in the year immediately preceding, serve with the Committee on Arrangements from the association in the county where the annual meeting is to be held. It was further recommended by the Committee to Survey the Annual Meeting, and adopted, that the Local Committee on Arrangements should be responsible for the arrangement of the program for the annual dinner of the Society.*

##### COMMITTEE ON POSTGRADUATE EDUCATION

Article X, Section 3, Par. 2 of the By-Laws of the Society provides:

The Nominating Committee shall appoint to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the Committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society, and to cooperate with University and other agencies within the state for the extension of postgraduate education of physicians.

##### EDITORIAL BOARD OF THE JOURNAL

Article X, Section 3, Par. 3 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other

member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the Editorial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board shall be selected so far as feasible, to represent the major division of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the state. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

##### COMMITTEE ON HONORARY MEMBERS AND DEGREES

Article X, Section 3, Par. 4 of the By-Laws of the Society provides:

The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

##### COMMITTEE ON HOSPITALS

Article X, Section 3, Par. 5 of the By-Laws of the Society provides:

The Nominating Committee shall nominate annually to the House of Delegates, a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue the continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

##### COMMITTEE ON INDUSTRIAL HEALTH

Article X, Section 3, Par. 6 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the chairman thereof. The function of this Committee shall be to inquire into health in industry for the purpose of making the information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

#### COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

Article X, Section 3, Par. 7 of the By-Laws of the Society provides:

At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

#### PROGRAM COMMITTEE

Article X, Section 3, Par. 8 of the By-Laws of the Society provides:

The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange a scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

#### COMMITTEE OF PUBLIC HEALTH

Article X, Section 3, Par. 9 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine, not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration, desirable legal enactments to promote public health within the State.

#### COMMITTEE ON STATE LEGISLATION

Article X, Section 3, Par. 10 of the By-Laws of the Society provides:

Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the Delegates to the American Medical Association and the Executive Secretary who shall serve as the executive officer of the Committee. The Chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this State, appropriate legislation for improving medical care and the public health within the state, advise the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

#### COMMITTEE ON PUBLIC RELATIONS

Article X, Section 3, Par. 11 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and cooperate with other committees of the Society in a program of public relations.

#### CANCER COORDINATING COMMITTEE

Article X, Section 3, Par. 12 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House



of Delegates annually a Cancer Coordinating Committee. The membership of this Committee shall be not less than seven and not more than nine members and shall at all times include the President of the Connecticut Cancer Society, the Chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this Committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

#### COMMITTEE ON PROFESSIONAL RELATIONS

Article X, Section 3, Par. 13 of the By-Laws of the Society provides:

At its semi-annual meeting in 1950, each component county association shall elect a past-president of the Association to serve on a State Committee on Professional Relations. The members so elected from the associations in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951, at which time the Hartford, New London, Windham and Middlesex county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years, and such election shall be biannually thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield and Tolland shall serve until the annual meeting of these county associations in 1952, at which time the New Haven, Fairfield, Litchfield and Tolland county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years and such election shall be held bi-annually thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except by invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional malpractice or negligence. The purposes of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society Secretary, either from the public or other physicians, they will be referred at once to the Secretary of the county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with the county association. If in the judgment of the appropriate Committee in the county association, the complaint should be heard by the State Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association to which a physician against whom charges have been brought belongs shall not vote on the final conclusion reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arriving at a decision, shall notify the physician against whom charges have been brought of its findings and disciplinary action to be taken, and at the same time, file a resume of its findings and action with the secretary of the County Association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of the Committee shall have the right of appeal to the Council before the expiration of fifteen days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

#### COMMITTEE ON MENTAL HEALTH

Article X, Section 3, Par. 14 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. The Committee shall be continuously informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

#### COMMITTEE ON THIRD PARTY PAYMENTS

Article X, Section 3, Par. 15 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

#### COMMITTEES APPOINTED BY THE COUNCIL

(not requiring election by the House of Delegates)

#### COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

The purpose of this committee is to continue and strengthen the historic close relationship between the Connecticut State Medical Society and the Yale University School of Medicine and to further the effectiveness of undergraduate and graduate programs of medical education.

#### ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The purpose of this committee is to serve in an advisory capacity to the Woman's Auxiliary of the State Medical

Society in matters of general policy, insofar as they relate to the program of the State Medical Society and upon request, to confer with the Auxiliary in the development of this program.

CONFERENCE COMMITTEE WITH CONNECTICUT  
PHARMACEUTICAL ASSOCIATION

The purpose of this committee is to provide a continuing conference group between the Connecticut State Medical Society and the Connecticut Pharmaceutical Association for the study and integration of the purposes and objectives of the common problems of the professions of medicine and pharmacy in Connecticut.

COMMITTEE ON NATIONAL LEGISLATION

The purpose of this committee is to be informed constantly concerning proposed national legislation relating to medical care and welfare. The committee shall advise the Council on details of proposed legislation in the fields of health and welfare and express its opinion, with appropriate approval, to Connecticut Representatives and Senators in the Congress of the United States. The Committee shall endeavor to keep members of the State Medical Society informed on trends and developments in national legislation that may be expected to affect medical service.

COMMITTEE ON STATEWIDE BLOOD BANK

The purpose of this committee is to promote the development of a statewide blood bank operating in the interests of the people and the medical profession. The committee is authorized, in the name of the Society, to cooperate with responsible agencies such as the American Red Cross, the State Department of Health, in prescribing professional policies of the operation of a blood bank.

COMMITTEE ON MEDICAL CARE OF VETERANS

The purpose of this committee is to cooperate with the Medical Section of the U. S. Veterans Administration and to represent the medical profession in Connecticut in all negotiations concerning the medical care of veterans, the payment for such care, and matters of general medical policy.

COMMITTEE ON RURAL MEDICAL SERVICE

The purpose of this committee is to develop a program of medical service for the rural population of Connecticut in cooperation with the Council on Rural Medical Service of the AMA.

ADVISORY COMMITTEE TO THE STATE BOARD OF EXAMINERS  
FOR NURSING

The purpose of this committee is, upon request, to cooperate and advise with the State Board of Examiners for Nursing in matters of general policy.

COMMITTEE ON THE CHRONICALLY ILL

The purpose of this committee is to be acquainted with the problems of the chronically ill in the State and to represent the Society in conferences of all agencies concerned with the care of the chronically ill.

COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

The purpose of this committee is to study maternal mortality and morbidity in Connecticut with the purpose of

making their best contribution toward lowering the mortality and morbidity rate from these causes.

ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

This committee was appointed, at the request of the Commissioner of Public Welfare of the State of Connecticut, to advise with him and the Medical Director of the Public Welfare Commission in all matters concerning medical care and hospitalization and to endeavor to maintain cooperation between the Commission of Welfare and the medical profession of the State.

CONFERENCE COMMITTEE FOR THE IMPROVEMENT OF THE CARE  
OF THE PATIENT

This is a joint committee, consisting of representatives from the State Medical Society, the State Nurses' Association, and the State Hospital Association. Its purpose is to study problems of mutual interest to the medical, nursing and hospital administrative professions with a view to finding solutions to problems involving improvement of the care of hospital patients.

COMMITTEE ON EMERGENCY MEDICAL SERVICE

The purpose of this committee is to integrate the planning and purposes of the medical profession with the Connecticut State Defense Council and to cooperate with the Council on Emergency Medical Service of the American Medical Association.

CONFERENCE COMMITTEE WITH THE CONNECTICUT STATE  
DENTAL ASSOCIATION

This committee is appointed to be the conference group with the State Dental Association and to discuss with that group problems of mutual interest to the two professions and bring the professions into closer relationship in all fields.

COMMITTEE ON STUDENT MEMBERS

This committee was appointed to advise the Council on policies relating to student members of the Society and to carry out programs for the encouragement and guidance of Connecticut residents engaged in the study of medicine.

COMMITTEE ON BUILDING MANAGEMENT

The purpose of this committee is to supervise the operation of the Society's headquarters building, including all details of its financing.

BOARD OF DIRECTORS, CONNECTICUT MEDICAL SERVICE

The By-Laws of Connecticut Medical Service provide that six members of the Board of Directors of that Corporation shall be appointed by the Council of the Connecticut State Medical Society. Although this group is actually not a committee of the Society, the six members so appointed have an important purpose. That purpose is to integrate the ideals and objectives of the medical profession with the operation of Connecticut Medical Service and to keep the medical profession of Connecticut informed concerning developments in the field of prepaid medical service.

COMMITTEE TO STUDY NEONATAL MORTALITY

The purpose of this committee is to inquire into the causes of neonatal mortality in Connecticut with the object of making suggestions for the removal of the causes of neonatal mortality.



CONFERENCE COMMITTEE WITH AMERICAN LEGION  
DEPARTMENT OF CONNECTICUT

The purpose of this committee is to confer with a similar committee from the American Legion Department of Connecticut on matters of mutual and public interest.

CONFERENCE COMMITTEE WITH THE CONNECTICUT BAR  
ASSOCIATION

The purpose of this committee is to confer from time to time with representatives of the Connecticut Bar Association on matters of mutual interest to the medical and legal professions.

### Meetings Held During July

- July 13-14—Connecticut Medical Examining Board  
(written examinations)
- July 13—Medical Advisory Committee to the State  
Welfare Department
- July 15—Special Committee to Study Third Party  
Payments for Medical and Ancillary Non-  
Surgical Services
- July 19—Executive Committee, Board of Directors,  
CMS
- July 20—Conference on Anesthesia Service in Hos-  
pitals
- July 27—Connecticut Medical Examining Board,  
Executive Meeting

### IMPORTANT NOTICE

The Placement Service for Physicians operated by the secretary's office has a large number of inquiries from young physicians, most of them completing military service, who wish to settle in Connecticut. They represent many special fields of medicine, particularly internal medicine and surgery. Some are seeking full-time employment. Anyone wishing an assistant or knowing of communities needing additional medical personnel or job openings are invited to communicate with the executive secretary.

### Felix Blanc Receives Honorary Degree

Ever since the days when Charter Oak Park in Hartford and Sage Park in Windsor were the scenes of those old time horse races Felix Blanc has been a friend of Connecticut medicine. Felix could always be found at one or the other of these tracks when his father-in-law was driving a thoroughbred on that day. The Brissies, father and son, were well known in our State, and now that harness racing in Connecticut affords only a nostalgic memory we find our genial State Director of Pharmacy receiving an Honorary Degree of Doctor of Pharmacy at the

fifty-third commencement exercises of the Rhode Island College of Pharmacy and Allied Sciences.

Charles Gilson, PH.G., PHAR.D., vice-president of the Rhode Island institution, presented Felix Blanc to President Claflin with a recommendation for the honorary degree. Dr. Claflin dwelt upon the record compiled by Director Blanc during the years in which he has been associated with Pharmacy in Connecticut. "It was a great privilege," he said, "to have the opportunity to make this presentation, through the powers vested in me as chairman of the Board of Trustees."

### The Birth of a Baby

The number of medical journals is constantly increasing, for better or worse. There are those in the United States who would eliminate all medical journals of a certain class, there are others who advocate but one journal to a specialty, and there is another group who throw up their hands in despair because they seem to be too busy to read. In the midst of this situation—for which we offer no solution except more careful screening of medical articles for publication—comes the announcement that beginning January 1, 1955 we are to have added to the family the *Journal of Chronic Diseases*.

This *Journal* is being established with Joseph Earle Moore, M.D. of Baltimore as editor as the result of about 600 favorable replies to a questionnaire sent to about 1,500 physicians who (eliminating duplicates) were drawn from the memberships of professional societies devoted to internal medicine and a selected list of public health officers with a special interest in chronic illness. Represented were practically all of the professors of medicine of leading American medical schools, younger internists with university appointments, and public health officers with special interests or responsibilities in the field. The remarkable fact about this questionnaire is that it produced a return of 60 per cent.

Dr. Moore is well known as associate professor of medicine and adjunct professor of public health administration at John Hopkins University. The publishers will be C. V. Mosby Company, St. Louis. A strong editorial board is in the process of formation.

The scope of the new *Journal* is the publication of significant articles dealing with these various phases of chronic illness, including review articles on selected topics, and editorials intended for an audience of general practitioners, internists, and physicians and other persons of medical and allied disciplines who must deal personally, or in the mass, with problems in this field. The *Journal* will avoid the publication of highly technical communications.

## THE HISTORIAN'S NOTE BOOK

### THE DOCTOR AS POET

EDWARD PODOLSKY, M.D., *Brooklyn, N. Y.*

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The Author. *Assistant Visiting Psychiatrist, Kings County Hospital, Brooklyn, N. Y.*

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FROM time immemorial there has been an intimate relationship between medicine and poetry. Apollo, the god of poetry, was the father of Aesculapius, the divinity of the healing art, and in Greek times those practicing medicine were dignified as "the children of Apollo." The figure of Apollo, the supreme god of medicine, together with the Muses and the serene goddess Pallas Athene, the immortal exemplar of reason and discipline, are the most ancient personification of all the great intellectual virtues.

Both medicine and poetry can be traced back to the childhood of the race. For while "poetry, like Beatrice, was born under a dancing star," medicine came into being with the first urgings to self preservation. Both have been man's spiritual companions down through the ages.

Probably the earliest physician-poet was Floridus, who lived in France in the 9th century and who wrote a lengthy collection of hexameters about the medicinal virtues of plants. The most famous poem of this type is the *Regimen Sanitas* written at the medical school of Salerno about 1101, its author being one, John of Milan. This work was addressed to the lay public, and was one of the earlier printed books in 1480; it passed through many editions.

The writing of verse by physicians, mostly epigrams and didactic epics, was common during Greek and Roman times. Nikandros of Kolophon (circa 133 B. C.), who was the son of a priest of Apollo and a physician, wrote two works of considerable length dealing with medical themes. Another doctor named Macer in the third century A. D. wrote a book on drugs entirely in verse.

The Golden Age of English poetry which began with Edmund Spenser's *Shepherd's Calendar* in 1579, and gave to the world the gloriously varied plenty

of Elizabethan poetry finds two physicians in the list of famous names, each of whom has given us some of the loveliest lyrics in the language. These two men are Thomas Lodge and Thomas Campion. Thomas Lodge (1558-1625), the son of old Sir Thomas Lodge, Lord Mayor of London, first tried his hand at law, then for a time was soldier, literary man, and later freebooter in the Spanish Main and Brazil. He finally turned to medicine and was graduated from Avignon and Oxford. He began practice in Warwick Lane, London, was successful as a physician and continued to write. Lodge in his practice of medicine was somewhat of an authority on the plague, from which he died in 1625. It is Lodge's most famous poem, *Roselynde, Euphues, Goldren Legacie*, which provided Shakespeare with his material for *As You Like It*. Lodge's chief volume of verse was *Phyllis* (1593), which contained some forty sonnets and lyrics and a long narrative poem. He is remembered for his little songs and madrigals, two or three of which, such as *Rosalind's Madrigal*, still find a place in every anthology of English verse.

Thomas Campion (?-1619), poet, musician and doctor of medicine, was born about the middle of the 16th century. Like Lodge, he was first a student of law in London, later turning to medicine and graduating from Cambridge. He had a most successful practice in London, and was a cultured urbane man with a wide circle of friends. His lyrics are perfect and exquisite examples of their kind. Campion was quite prolific as a poet and his poetry was widely read in his time.

Abraham Cowley (1618-1667), a native of London, scholar of Trinity College, Cambridge, and later of Oxford, spent his earlier years in the Royalist cause, living for a time in France as secretary to the exiled Queen Henrietta Maria. In 1657 he became a doctor of medicine. During his life time he was regarded as the greatest English poet, and on his death was buried in Westminster Abbey. In literary history Dr. Cowley is remembered as one of the first



to establish what may be termed the modern prose style.

The next figure, Henry Vaughan (1621-1693), is one for whom poetry is deeply in debt to medicine. Vaughan the "Silurist," as he was called because of his native place among the Silures in the county of Brecknockshires in South Wales, was educated at Jesus College, Oxford, and was a staunch Royalist, being imprisoned for a time during the British Civil War. He practiced medicine in his native land and achieved a considerable reputation. His literary work was an avocation pursued for the love of writing. His poem, *The Retreate*, provided Wordsworth with some part of his inspiration for the famous *Ode on the Intimations of Immortality*. Some half dozen of his poems are the finest expression in our language of spiritual aspiration. As a writer of religious verse he is of the company of George Herbert and John Donne.

One minor poet completes the role of 17th century physician-poets. Martin Llewellyn (1616-1682), scholar and cavalier, fought for the Royalist cause and afterwards practiced in London. Later he became a Fellow of the Royal College of Physicians, and with the Restoration he was made physician to Charles II and Principal of St. Mary's Hall, Oxford. His best known work was *Mere Miracles*. In his scientific work he is regarded as the founder of comparative helminthology and he did much to refute the theory of spontaneous generation. He was a distinguished poet in his day, publishing *Bacco in Toscare*, *Arianna Inferna* and other works.

#### EIGHTEENTH CENTURY

With the single exception of Oliver Goldsmith the physicians of the 18th century produced little poetry of worth. In passing we may mention two physician-poets, John Wolcott and Mark Akenside. John Wolcott (1738-1819), who wrote under the pseudonym of Peter Pindar, figured in some of the literary quarrels of his day. He had great satirical ability, but his humor at times was rough and libelous. His poem, *Satyr Against Wit*, brought attacks from Dryden, Pope, Steele and Garth.

Mark Akenside (1721-1770) became physician to the Queen and was a very distinguished medical man. He dabbled in poetry and attained some degree of favorable notice. His principal work, *The Pleasures of the Imagination*, is a long didactic poem in blank verse. He also wrote a great many odes in the manner of Gray and Collins. His arrogant manner made him

many enemies, and probably on this account he was satirized by Smollett in *Peregrine Pickle*.

The greatest of the Eighteenth century doctor-poets was Oliver Goldsmith (1728-1774). After obtaining his B.A. at Trinity College, Dublin, and spending several advances of money from his family in an attempt to get out of Ireland, he turned up in Edinburgh where he studied medicine. He then wandered over Europe, playing on the flute and debating at the universities for a livelihood. He returned to England where he practiced medicine. His attempts at practice were as happy-go-lucky and as prodigal as his nature. He at length gave up medical practice altogether and began to devote all his time to literature.

Goldsmith's contributions to poetry are immortal. His *The Deserted Village* is one of the greatest poems of all time and many of its couplets have become part of our daily speech.

#### NINETEENTH CENTURY

The roll of nineteenth century medical poets contains the names of two who were outstanding, John Keats (1795-1821), the greatest poet in English literature, and Thomas Lovell Beddoes (1803-1849), a poet-physician whom many have hailed as the successor of John Keats. Beddoes was the son of a celebrated English physician, and after leaving Oxford, went to the Continent where he received his medical degree from the University of Wurzburg. An orderly life was constantly shattered by his becoming involved in political intrigue. He finally committed suicide at the age of forty-six.

Beddoes' works are cast mostly in the form of the poetic drama. He is an Elizabethan dramatist of the company of Marlowe and Green, born out of season. His chief work is the play, *Death's Jest Book*, upon which he worked for more than twenty years. It is the greatest dramatic variant in English on the old Dance of Death theme which has haunted painters and writers for centuries. The scenes are crowded with murder, death, ghosts, skulls, all cast with a strange beauty that is peculiar to Beddoes. His is the concentrated grim irony and harsh mirthless laughter of one who is preoccupied with death. The dark background of the play is lit up with an unearthly beauty by many haunting lyrics and dirges.

Of John Keats one writer has said "Medicine suffered a loss, but the world gained when this prodigal son strayed off into a far country." John Keats, a spirited pugnacious lad and a natural leader

among his fellows, was left an orphan at the age of fourteen. In the following year he was apprenticed by his guardian to Mr. Hammond, a surgeon of Edmonton, in whose service he spent more than four years. The young apprentice already had a passion for literature, and during these early years completed a translation of the *Aeneid*. But it was the reading of Spenser's *Faerie Queen*, through which he ranged with delight, that awakened his genius and his earliest compositions are in imitation of Spenser. The earliest signs that Keats had seriously committed himself to poetry occurred in February, 1815, when he impulsively handed his friend, Clarke, a sonnet entitled, *Written on the Day that Mr. Leigh Hunt Left Prison*. He was in his nineteenth year at that time and still an apprentice.

While none of these earlier efforts were precocious, in midsummer of the same year there was a sudden blaze of genius. Keats and Clarke had read a borrowed folio copy of Chapman's *Homer* far into the small hours of the morning. Keats, who left for home in a state of excitement, composed and sent back a sonnet which Clarke found on his breakfast table when he came down in the morning. It bore the title, *On First Looking Into Chapman's Homer*, and it is one of the perfect poems in English literature. In this poem the young apprentice for the first time "speaks out loud and bold," in accents which were to widen the boundaries of those very realms "which bards in fealty to Apollo hold." Poetry was already the interest of his heart.

However, he passed with credit his examination as licentiate at Apothecaries' Hall on October 1, 1815 to continue his studies. He was a diligent student, sufficiently outstanding to attract the attention of Sir Astley Cooper, one of the leading surgeons of the day. During the first winter and spring in London he lived the typical life of drudgery of the medical student, rooming with two fellow students in dingy lodgings in the Borough near Guy's Hospital. While here he wrote the two sonnets:

"O Solitude! If I must with thee dwell,

Let it not be among the jumbled heap of murky dwellings."

and

"To one who has been long in the city pent,

'Tis very sweet to look into the fair

And open face of heaven."

In the course of his first year as a student in Guy's, Keats moved to lodgings over a tallow chandler's shop in St. Thomas's Street. Here one evening while his fellow student Stephens was studying, Keats broke out with the announcement that he

had composed a new line of poetry:

"A thing of beauty is a constant joy."

To Keats's inquiry Stephens replied that he liked the line, but it seemed wanting in some way. After an interval of silence came Keats' rejoinder:

"A thing of beauty is a joy forever."

And so there was born in the little room of a trio of medical students "one of the imperishable lines of English poetry."

Keats continued to do his work regularly and with considerable credit. But the poet was crowding out the medical student. As he himself says: "The other day, during the lecture, there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray, and I was off with them to Oberon and fairy-land." He worked as a surgical assistant, but always seemed curiously apart from the work. He later told a friend: "My last operation was the opening of a man's temporal artery. I did it with the utmost nicety, but, reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again." He qualified with credit in July, 1816, but after a holiday at Margate returned to London resolved to write poetry, and with the ambition to be among the great. Medicine was already forgotten, and with an intensity which few poets, even the greatest have shown, Keats gave himself up to his work as a poet.

Medical practice was never distasteful to Keats; he never showed for it the dislike with which so many genuises have regarded the more workaday vocations. To him it was like sojourning in a far country.

Keats wrote poetry all the years of his too brief life. To him who longed for freedom from torment, death came peacefully on Friday, February 23, 1821. On Sunday morning they carried him to the Protestant Cemetery in Rome and laid him to rest amid the ruins of the old Aurelian Wall. He was in his twenty-sixth year. And Shelley wept bitterly for his youth, his loveliness, his unfinished expectation, his elemental majesty.

"He has outsoared the shadow of our night;  
Envy and calumny, and hate and pain,  
And that unrest which men miscalled delight,  
Can touch him not and torture not again."

The poet-physician is still carrying out the traditions of the many who came before him. There are many practising this art in this country and in other countries throughout the world. There is a healthy affinity between poetry and medicine.



## AMA — SAN FRANCISCO — JUNE 21-25

Total Registration 43,000; Physicians 12,000

## FROM CONNECTICUT

Thomas P. Murdock, Meriden—Member, Board of Trustees.

Creighton Barker, New Haven—Member, House of Delegates.

Thomas J. Danaher, Torrington—Chairman, Reference Committee on Insurance and Medical Service, House of Delegates.

Henry A. Archambault, Taftville  
Abraham Bernstein, Bridgeport  
Theodore F. Bevens, Waterbury  
Charles Lee Buxton, New Haven  
William T. Clark, Bridgeport  
Martha L. Clifford, Hartford  
Sidney A. Chait, Torrington  
Ilona K. de Suto Nagy, West Haven  
A. Della Pietra, Waterbury  
Madeline Fiske, Stamford  
Nathan H. Friedman, Stratford  
Francis P. Guida, New Haven  
William H. Horton, Windsor

Frank R. Hurlbutt, Greenwich  
Ben B. Johnson, New London  
Carl E. Johnson, New Haven  
Leon Kaplan, Bridgeport  
Joseph Kaschmann, West Hartford  
E. H. Kirschbaum, Waterbury  
Theodore G. Klumpp, New York  
S. D. Kushlan, New Haven  
Joseph H. Kott, Torrington  
T. T. Mackie, Westport  
Edward F. Malloy, Stamford  
Egmont J. Orbach, New Britain  
Kurt Oster, Bridgeport

Philip F. Parshley, West Hartford  
John R. Paul, New Haven  
Edwin G. Reade, Watertown  
Benjamin Sherman, Bridgeport  
William A. Sinton, Danbury  
E. Myles Standish, Hartford  
Hilda C. Standish, West Hartford  
Marcel Thau, Hartford  
Lee D. Van Antwerp, Chicago  
Kathryn E. Verie, New London  
Benedict Vicas, Hartford  
Jerrold Von Wedel, Cos Cob  
Victor G. H. Wallace, Hartford

Stevens J. Martin, Hartford—Member, Executive Committee, Section on Anesthesiology.

Stanley H. Osborn, Hartford—Member, Council on Constitution and By-laws.

Oliver L. Stringfield, Stamford—Chairman, Section on Pediatrics.

Stanley B. Weld, Hartford—Clerk, House of Delegates.

## MEDICAL ETHICS

The House of Delegates acted on more than sixty resolutions. Among these was the controversial resolution concerning the principles of medical ethics introduced by the New York delegation. The House referred this to the Judicial Council of the AMA. This resolution proposed a declaration that "any medical care plan, company or organization which advertises for subscribers and directs such subscribers to a restricted panel of physicians for medical care is advertising for the benefit of the physicians involved." The resolution stated that contract practice per se is not unethical. It added, however, the following: "A contract with a hospital organization or political subdivision, which is supported in whole or in part by public funds, or by solicitation of private subscribers to diagnose and treat patients is ethical only when such diagnosis and treatment is for a patient who is a public charge." Since the Judicial Council has jurisdiction on all questions of medical ethics it was requested to con-

sider the New York resolution in connection with an investigation of the Principles of Medical Ethics in relation to all prepaid medical care plans.

## FEE SPLITTING

The House of Delegates adopted a report from the Judicial Council to the effect "that when two or more physicians actually and in person render service to one patient they should render separate bills." "Under no conditions shall it be considered ethical for a physician to submit joint bills unless the patient specifically requests it and unless the services were actually rendered by the physicians as set out in the bill." Joint billing to some of the nonprofit insurance companies which insist on this procedure is not unethical since the bill is being paid in most cases by two checks direct to the physicians. Added to this report was a resolution which was passed which "firmly opposes fee splitting, rebating or payment of commissions in any guise whatever. And it further opposes any mechanism that encourages this practice."

## FEE SCHEDULES

In his presidential address, Edward J. McCormick called upon the medical profession to take the guess work out of medical costs by adopting average fee schedules on an area or regional fee basis. The House felt that this was a problem requiring considerable study and so referred it to the Board of Trustees. A report will probably be made to the House at the November session in Miami.

## OSTEOPATHY

Several resolutions were introduced pertaining to the relations between osteopathy and medicine and in addition the Committee for the Study of Relations between Osteopathy and Medicine submitted a report. No action was taken on this controversial matter since it was felt a decision could not be reached until the house of delegates of the American Osteopathic Association acts favorably upon the recommendation of its Conference Committee permitting an evaluation of education in schools of osteopathy. It is anticipated that final action will be taken at the next meeting of the AMA House of Delegates in Miami.

## FOREIGN PHYSICIANS

Three resolutions were introduced relative to foreign medical school graduates. Two of these called for disapproval of intern or resident training for foreign graduates ineligible for licensure unless they are bona fide graduates selected for training in this country who will return to their own countries at the termination of their training. The other resolution introduced by Creighton Barker called for the devising and developing of "a plan to determine and evaluate the educational competence of said foreign graduates for admission to licensing examinations of the various State Boards of the United States, the District of Columbia and the territories of the United States."

The Committee on Evaluation of Foreign Medical School Graduates in its report felt that it was probably physically impossible to evaluate foreign medical schools and that the cost would be prohibitive. The question of screening individual graduates met with general approval. The Committee recommended to the House of Delegates "that this problem be referred back to the Council on Medical Education for continued general study" with certain specific proposals looking toward the screening of individual graduates. This report together with the three reso-

lutions was referred by the House to the Council on Medical Education.

## SALK POLIO VACCINE PROJECT

The House of Delegates criticized the National Foundation for Infantile Paralysis for instituting its Salk polio vaccine project without consulting the American Medical Association. Dr. H. E. Van Riper, medical director of the Foundation, issued a statement to the press following the action of the House in which he said that "every step in the development and trial of the polio vaccine was submitted to, supervised and approved by a committee of distinguished scientists, all of whom are members of the American Medical Association." He called attention to the fact that the vaccine is being tested at this time to determine its usefulness through trials that have proceeded with great success in 217 communities and only after approval by the local county medical societies, all constituents of the AMA.

## SOCIAL SECURITY FOR PHYSICIANS

The House went on record as opposed to compulsory coverage of physicians under Social Security, but approved voluntary coverage for those physicians desiring it. The principle of this resolution is the same as that embodied in HR9366.

## GAMMA GLOBULIN

The Texas delegation introduced a resolution requesting the Blood Bank Committee of the AMA "to reevaluate the means and methods concerning the distribution of gamma globulin so that it can be released for normal distribution." This was approved by the House.

## NATIONAL BLOOD PROGRAM

Two resolutions were introduced into the House of Delegates pertaining to the National Blood Foundation. Both were adopted. These called for a reexamination by the Blood Bank Committee of the AMA of "its position and viewpoint concerning the National Blood Foundation to the end that the AMA should approve, foster and support a program related to the medical operation of blood banking that will provide for coordination of blood bank activities in times of national disaster or emergencies, but will oppose a program that would take from a local county medical society the local determination of the need for and type of blood banking program that shall serve the community, including any attempt at regimentation of blood banking activity at the local level which would interfere with free enterprise."



In its report which was approved the Committee on Blood expressed its intent to establish a program which is entirely voluntary and which will require the active cooperation of the great majority of blood banking facilities. The AMA would contribute at least 40 per cent of the necessary funds to operate the plan and the American National Red Cross has agreed to match this contribution. It is anticipated that in five years the plan would become self supporting.

#### CIVIL DEFENSE

The House received two resolutions calling for the elevation of the Health Division of the Federal Civil Defense Administration. One resolution was approved. The other resolution would set up a Department of Civil Defense within the Department of Defense with equal status with the Department of the Army, Navy and Air Force, headed by a secretary of equal rank with the secretaries of the other three departments and with the chief operational officer of Civil Defense functioning as a member of the Joint Chiefs of Staff. This resolution was referred to the AMA Council on National Defense.

#### THE DOCTOR DRAFT LAW

A resolution was passed requesting "the Director of the Office of Defense Mobilization to defer if practicable the induction or involuntary recall of physicians during the second quarter of 1955 other than those liable under the basic Selective Service Act." (The present Doctor Draft law expires June 30, 1955.)

#### VETERANS MEDICAL CARE

Accepting a report by the Reference Committee on Legislation and Public Relations, the House adopted two strong resolutions condemning the present practice of establishing service connection for veterans' disabilities by legislative fiat. In recommending passage of both resolutions, the committee said:

"The study of the chronological expansion by law and regulation, together with evidence presented of pending legislation now before a Congressional Committee, emphasize all too clearly the imperative need of decisive action on the part of the American Medical Association.

"It is the opinion of the Committee that the time is at hand when the American Medical Association and its component societies should go all out in preventing this unscientific method of determination

of service connected disabilities, and that we respectfully request that copies of these resolutions be transmitted to the Congress of the United States and other appropriate federal agencies."

In connection with veterans' medical care, the House also adopted recommendations by the Reference Committee on Insurance and Medical Service which reaffirmed the policy on nonservice connected disabilities established at the 1953 annual meeting, and which commended the informational program carried out since then by the Committee on Federal Medical Services of the Council on Medical Service.

#### SEAL OF ACCEPTANCE

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The report said that the standards and principles of the program will be maintained as guides and recommendations for all groups operating or establishing plans. The House, on recommendation of the Reference Committee on Insurance and Medical Service, adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans.

#### MISCELLANEOUS RESOLUTIONS

The House of Delegates sent a resolution changing the definition and scope of oral surgery to the Board of Trustees and required the latter to appoint a committee to study this subject.

Another resolution requesting the Council on Medical Education to "investigate and set up a system of standardization for smaller hospitals in keeping with their general size, personnel and facilities" was referred to the Committee of the Joint Commission on Smaller Hospitals.

The House approved the present National Intern Matching Program. It also approved certain changes in the approved residencies and fellowships in internal medicine, added a section to the present approved residencies and fellowships in occupational medicine, and revised those in proctology.

The discontinuance of the registration of hospitals by the Council on Medical Education and Hospitals was approved and in its place the Joint Commission on Accreditation of Hospitals is to be requested to undertake registration of hospitals in addition to its present accreditation activities.

A resolution purporting to reduce attendance at a required number of hospital staff meetings was referred to the Joint Commission on Accreditation of Hospitals.

Changes in the present service membership in the AMA were referred to the Board of Trustees. At the same time the House adopted a resolution endorsing a special type of membership for interns, residents and fellows in approved hospitals who are graduates of approved schools.

Organizations which solicit and collect moneys from the public for the advancement of medical knowledge and medical care in specific fields will be urged to allocate a proportion of their funds to the American Medical Education Foundation for the general program of the schools.

The House approved legalization of the distribution of narcotics at cost or free under certain safeguards which would set up narcotic clinics in cities where needed under the aegis of the Federal Bureau of Narcotics and prevent self administration by and forcible confinements of addicts.

The House voted to continue the holding of the annual Clinical Meetings.

Approved the establishment of a program of medical military scholarships with appropriate safeguards limiting the number of students involved;

Approved the extension, on a voluntary basis, of the Medical Education for National Defense program which currently is in operation in five medical schools as a pilot study, and

Authorized the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at meetings of the Council, and asked for a report at the December meeting.

#### WOMAN'S AUXILIARY GIVES AMEF \$8,000

A check for \$5,472 was presented to the American Medical Education Foundation by the Woman's Auxiliary during the San Francisco session. A memorial fund totalling \$2,477 in honor of a recent president of the Auxiliary who died last August was also given to AMEF. Two \$100 presentations were made to the World Medical Association and the Committee on Careers in Nursing by the Woman's Auxiliary.

#### DISTINGUISHED SERVICE AWARD

William Wayne Babcock of Philadelphia was named 1954 recipient of the AMA's Distinguished

Service Award for outstanding contributions to medicine and humanity. Dr. Babcock was professor of surgery and clinical surgery at Temple University from 1903 to 1944. The other two candidates nominated for this honor by the Board of Trustees were Howard T. Karsner of Washington, D. C. and Torald H. Sollman of Cleveland, Ohio.

#### SCIENTIFIC EXHIBITS

The Hektoen award comprising three gold, silver and bronze medals presented for exhibits of original investigation which are judged on the basis of originality and excellence of presentation were allocated as follows:

Gold Medal to a group from Houston, Texas for the exhibit on Aneurysms and Thrombo-Obliterative Disease of the Aorta. Silver Medal to a group from Atlanta, Georgia for the exhibit on Paper Electrophoresis in Clinical Diagnosis. Bronze Medal to a group from Portland, Oregon for the exhibit on The Melanocyte Stimulating Hormone.

The Billings Medal winners who received gold, silver and bronze medals for exhibits which do not exemplify purely experimental studies but are judged on the basis of excellence of presentation were awarded as follows:

Gold Medal to a group from New Orleans and Baton Rouge, Louisiana for the exhibit on Fungous Diseases. Silver Medal to a group from Los Angeles, California for the exhibit on Portal Hypertension. Bronze Medal to a group from the Department of Medicine and Surgery of the U. S. Navy for the exhibit on Naval Medical Service with the First Marine Division in Korea—Medical Installations, Casualty Evacuation, Arterial Injuries, General Surgery, Orthopedic Surgery and Blast Injuries.

#### SPECIAL CITATIONS

Two special citations were presented by the Association during the San Francisco meeting. During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallas, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline & French Laboratories of Philadelphia for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the company by Mr. Francis Boyer, president.

The closing session also brought the announce-



ment that the California Medical Association had presented a check for \$100,000 to the American Medical Education Foundation.

#### ELMER HESS THE NEW AMA PRESIDENT-ELECT

Walter B. Martin of Norfolk, Virginia automatically became president of the American Medical Association and Elmer Hess of Erie, Pennsylvania was chosen president-elect on the first ballot. Dr. Hess won the election over two other nominees, Harvey B. Stone of Baltimore and Edwin S. Hamilton of Kankakee, Illinois. Clark Bailey of Harlan, Kentucky became the new vice-president by a margin of one vote over his opponent, McKinnie Phelps of Denver. Reelected were George F. Lull as secretary and Josiah J. Moore as treasurer, both of Chicago; also James R. Reuling of Bayside, N. Y. as speaker, Vincent Askey of Los Angeles as vice-speaker, and David B. Allman of Atlantic City and F. J. L. Blasingame of Wharton, Texas as members of the Board of Trustees. Edward R. Cuniffe of New York who had served as chairman of the Judicial Council for many years declined to run for reelection. His place on the Council was filled by J. Marshall Hutcheson of Richmond, Virginia.

Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, Hartford, was elected Chairman of the Section on Nervous and Mental Diseases of the American Medical Association.

#### FUTURE AMA MEETINGS

The schedule of future sessions as selected is as follows:

	ANNUAL	CLINICAL
1954	—	Miami
1955	Atlantic City	Boston
1956	Chicago	Seattle
1957	New York City	Not selected
1958	San Francisco	Not selected
1959	Atlantic City	Not selected

#### SAN FRANCISCO IN JUNE 1954

Nature was unusually kind to us this year by affording a week of sunny weather and a minimum of fog. Many physicians arrived several days early to attend sessions of various special societies, committees and councils. The physicians and wives of San Francisco lived up to their reputation as genial hosts providing a variety of entertainment to suit the needs and wishes of all. Even some of the cable cars continued to operate so that Nob Hill and Fisherman's Wharf could be reached by the aid of this old and trusted means of conveyance.

## Connecticut Committee on Foods, Drugs, Cosmetics and Devices

### Report of Meeting Held at New Haven on March 25 1954

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Dental Association, Dr. William Kirschner; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Mr. Felix Blanc, representing the Pharmacy Commission; Dr. Barnett Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

#### THE ASSMAR HICCUP-CURING MACHINE

At the last meeting Dr. Hart (chairman), Dr. Greenhouse and Dr. Wedberg had been appointed a subcommittee to investigate and report on this machine. Dr. Hart reported in part as follows:

"This machine was publicized in the *Hartford Courant* of January 10, but the *Courant* article did not tell the whole story, so this afternoon Dr. Wedberg and I went to Jewett City to see the machine. Mr. Assmar runs the Griswold Package Store; the machine is now over the office of Dr. Fred Barrett, the local health officer. A State Food and Drug Commission inspector (R. B. Ward) saw the machine on January 14 and made a report. Mr. Assmar told us of the 'cures' made by his machine; among the patients was a priest who had had hiccups for seven months who was cured after two treatments, subsequently gaining 55 pounds. Mr. Assmar does not ask for any money, and the only fee is the doctor's charge for a physical examination. The machine looks like a white platform scale with a motor in back which rotates one end of the platform. The patient stands on the platform or sits on a chair placed on it and drinks water; the treatment lasts about an hour and a half. Mr. Assmar used to have a hood to fit over the patient's head and a cup with a small electric charge, but these have been abandoned. Mr. Assmar does not claim to know how the machine works. All cases have been treated successfully with the possible exception of one 290-pound man; all were under the doctor's care. Mr. Assmar is a Lebanese who says he gets nothing out of it."

Dr. DeVita remarked that this was apparently an experiment still going on.

Dr. Hart added that Mr. Assmar, while in Lebanon, had studied at the university and had ambitions to be a doctor. He had had the machine built through a lawyer friend, Frank Odlum; he was not interested in publicity but Odlum was. The machine had been patented. Contacts with patients were largely through liquor salesmen.

On motion of Dr. DeVita it was voted that the Committee not make any recommendation on the Assmar Hiccup-Curing Machine because of insufficient evidence, but continue to watch the device and the claims made for it.

#### "FLAVETTES LOZENGES"

Mr. Plank called to the members' attention a sample of a product of the above name, being sold by Sage, Allen & Co., Inc., Hartford, for \$2.06 a package. These lozenges, which were intended to cure the smoking habit, were labelled as containing 3 mg. of benzocaine, with flavorings of saccharin, licorice extract, powdered ginger and oils of anise, wintergreen, peppermint, coriander and cloves.

Dr. Hewitt said that his school had been working on the antismoking problem for an industrial firm; they had tried benzocaine and other local anesthetics and found them to work for some people; he did not consider the dose of benzocaine in the "Flavettes Lozenges" to be harmful. Dr. Greenhouse remarked that he had heard that dermatologists were afraid of benzocaine, but Dr. Hewitt replied that this was only in connection with long-time use. Dr. Bonnycastle concurred with Dr. Hewitt that the dose was too small to be dangerous. To a question of Dr. DeVita as to whether sensitivity to benzocaine could be acquired over a period of time, Dr. Bonnycastle replied: "Maybe, but someone has pointed out that people who had to keep using these things for long would give up eventually and keep on smoking."

On motion of Dr. Bonnycastle it was voted that the Committee found no evidence that benzocaine was toxic in the dosage present in "Flavettes Lozenges."

#### "NUTRILITE FOOD SUPPLEMENT"

Mr. Plank related that a man who recently started selling "Nutralite Food Supplement" had asked him whether the product was O.K. Mr. Plank said that answering this man involved the legal question of

whether "Nutralite" was a food or a drug, and this question hinged on whether the quantity of vitamins in the capsules was enough to take the product out of the food class. He displayed samples of the three sizes of "Nutralite" packages ("Nutralite XX," "Nutralite X" and "Nutralite Junior").

These samples were passed around, and particular note was taken of the fact that the capsules in the "Nutralite XX" package were labelled as containing 25,000 U.S.P. units of vitamin A and 2,500 units of vitamin D. Reference was made to the recent discussion on hypervitaminosis A and D. (See the Report of the December 3, 1953 meeting.)

On motion of Dr. Wedberg it was voted that George R. Cowgill, PH.D., professor of nutrition of the Department of Physiology of Yale University, be asked for an opinion on whether the "Nutralite" doses were high enough to bring the product above the food classification.

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## THE DOCTOR'S OFFICE

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Joseph J. Bowen, Jr., M.D. announces the transfer of his office to 111 West Main Street, Waterbury, for the practice of internal medicine and cardiology.

Jean G. De Chabert-Ostland, M.D. announces the opening of an office for the practice of psychiatry at 37 Garden Street, Hartford.

Frank R. L. Egloff, M.D. announces the removal of his office for general psychiatry to 1007 Farmington Avenue, West Hartford.

Frank F. Espey, M.D. announces the opening of an office for the practice of neurological surgery at 123 Mallard Street, Greenville, South Carolina.

Donald S. Hauss, M.D. announces the opening of an office for the practice of internal medicine at 301 Farmington Avenue, Hartford.

Walter P. Kosar, M.D. announces the opening of an office for the practice of obstetrics and diseases of women at 36 Woodland Street, Hartford.

William G. Leeds, M.D. announces the opening of an office for the practice of medicine at 1005 Farmington Avenue Plaza, West Hartford.

Chester A. Weed, M.D. announces the removal of his office for the practice of ophthalmology at 1007 Farmington Avenue, West Hartford.



## NEWS FROM WASHINGTON

### A Dead Duck

The reinsurance bill (HR8356) is considered dead by House Republican Leader Halleck because it does not go far enough to suit most Democratic Congressmen and is too radical for most Republicans to swallow.

The bill sent back to the Commerce Committee would authorize the federal government to underwrite up to 75 per cent of the losses suffered by private and nonprofit insurance firms as a result of voluntary expansion of their health and medical programs.

The reinsurance program would be given a start with a 25 million dollar government fund. Later, it would be supported by premiums paid in by co-operating firms. The bill would stress continued State control of insurance companies.

The AMA has officially opposed this bill for the following reasons:

1. There is a very definite question as to the need of government intervention in the insurance field at this time. The combined assets of the insurance companies offering health reinsurance facilities amount to approximately two billion dollars.

2. The growth of prepayment voluntary health insurance has been extremely rapid. At the present time, at least 93 million people out of a total insurable population of 130 million have some form of protection. This fact plus the demonstrated ability of the insurance agencies to meet the needs and demands of the people indicates to us that it is not necessary for the federal government to enter this field.

3. Reinsurance will not overcome the inertia of the unwilling buyer unless the government provides a subsidy for the purpose of selling insurance at a price below the cost of servicing the contract. This, we believe, would be objectionable.

4. Reinsurance does not provide a means of making insurable what would otherwise be an uninsurable risk.

5. Reinsurance does not reduce the cost of insurance unless subsidy is introduced.

### HEW Budget Passes; \$11 Million Above Requests

The Senate and House gave their final approval June 30 to a \$1,663,413,761 budget for the Department of Health, Education, and Welfare to run its many programs for the fiscal year beginning the following day. The total as sent to the White House for the President's signature is \$10,904,500 more than the administration had requested. Nearly all of the increases voted involve medical programs. Congress a year ago voted \$1,927,432,261 for HEW in fiscal 1954; the bulk of the reduction for this year is attributed to decreased public assistance grants to States. The following table lists some of the more important health items:

AGENCY AND ITEM	YEAR ENDING ADMINISTRATION'S APPROPRIATED JULY 1, 1954 RECOMMENDATION BY CONGRESS (FISCAL 1954) (FISCAL 1955) (FISCAL 1955)		
Total, U. S. Public			
Health Service	\$232,962,500	\$219,089,500	\$228,060,000
Hill-Burton	65,000,000	75,000,000	75,000,000
Cancer Institute	20,237,000	19,730,000	21,737,000
Mental Health	12,095,000	12,460,000	14,147,500
Heart Institute	15,168,000	14,570,000	16,668,000
Arth. and Metab.			
Dis.	7,000,000	7,270,000	8,270,000
Microbiology	5,738,000	5,930,000	6,180,000
Neurology and			
Blind.	4,500,000	4,763,000	7,600,500
Hospitals and			
Care	33,100,000	33,040,000	33,000,000
Gen. Asst. to			
States	13,250,000	17,665,500	13,000,000
Total, Office of Voc.			
Rehabilitation	23,655,500	19,825,000	23,635,000
Total, Food and Drug			
Administration	5,200,000	5,200,000	5,100,000

This became Public Law No. 472 on July 2 upon the President's approval.

### Hill-Burton Expansion Passes; On Way to White House

An expansion of the Hill-Burton hospital construction program now is assured. It will mean a three-year program of federal grants as follows: \$20 million annually for diagnostic or treatments centers,

\$20 million for hospitals for the chronically ill, \$10 million for rehabilitation facilities, and \$10 million for nursing homes. All will have to be "public or nonprofit." These grants will be in addition to the regular Hill-Burton funds for complete hospitals, set at \$75 million for the fiscal year that started July 1. The last important obstacle was cleared June 30, when the House accepted Senate amendments to the expansion bill, HR8149. The most important Senate amendment would: (a) require repayment of the federal share if the facility were converted to other use within 20 years, (b) allow the States to shift money from one category to another (except for rehabilitation grants), and (c) authorize grants to clinics under the supervision of dentists as well as physicians. An appropriation bill will be presented shortly to provide funds for the first year's operation of the new program. This is the first major health bill of the Eisenhower administration to receive final approval in House and Senate this session. Presidential signature was affixed soon after passage.

### VA Planning on 110,000 Daily Patient Load For Fiscal 1956

Veterans Administrator Harvey Higley says the agency is planning on a 110,000 daily patient load for its hospitals in fiscal 1956 (starting July 1, 1955). On the basis of a current staffing of 114,000 beds and a 90 per cent occupancy, the new figure would mean approximately 8,000 more beds would have to be added. One estimate of hospital experts is that the cost of the 8,000 additional beds would be well in excess of \$120 million. Commented Mr. Higley in testimony before House Veterans Affairs Committee on the 110,000 figure: "We believe that isn't far off from the Bureau of the Budget's thinking, too." For the current fiscal year, the daily average patient load has been 103,000. The fiscal 1955 budget for VA providing for a daily load of 105,000 patients went to the White House this week. Under questioning on the 1955 budget, Mr. Higley said VA would be able to do a better job during the next year if it had another \$6 million. However, Reps. Pat Kearney and William Ayres raised the point that this extra money would be for nonservice connected cases and that it would, on that basis, be difficult getting Congress to go along.

### Reserve Training Duty

Members of medical components of Naval Reserve will have opportunity to enroll for the follow-

ing courses of instruction in 1954-55, according to fiscal year training program just announced. Seminar for commanding officers of medical companies, October 4 in Washington (6 days); special weapons, isotopes and military medicine, February 28 in San Francisco (5 days); 14 day course in field medicine in August, October, March and May at Camp Pendleton, California; general military medical training (14 days) in October and March at Naval Medical School here; insect and rodent control at Jacksonville, Florida, monthly throughout year (14 days); malariology and insect control at Alameda, California, monthly throughout year. Detailed information obtainable from Naval District Commandants.

### U. S. Health Manpower by Counties Charted

Just published by U. S. Public Health Service is a 247 page reference work on nationwide distribution of medical, dental and paramedical personnel. Data are presented by counties, in tabular form, on 16 occupations. Population census of 1950 furnished statistical basis of this study, Part 4 of an inventory whose previous sections were devoted to physicians exclusively, nursing and medical social workers. Census Bureau figures came to total of 1,327,674 persons engaged in the 16 occupations, 398,534 of whom were professional nurses. Other categories are broken down as follows, figures in parentheses indicating number per 100,000 population:

Physicians and surgeons, 191,947 (127); attendants in hospitals and other institutions, 204,378 (136); attendants in practitioners' offices, 40,811 (27); practical nurses, 135,902 (90); pharmacists, 88,116 (58); dentists, 74,855 (50); medical and dental technicians, 76,323 (51).

"Therapists and healers," 24,424 (16); dietitians and nutritionists, 22,400 (15); opticians and lens workers, 19,161 (13); optometrists, 14,596 (10); veterinarians, 13,379 (9); chiropractors, 12,903 (9); osteopaths, 5,149 (3); psychologists, 4,796 (3).

Quotation marked classification above is so designated because it is a catch-all which dubiously embraces chiropodists and naturopaths, occupational therapists and faith healers, physical therapists and gymnasts (sic). Even "medicine man" is in this grouping. Note: The volume (entitled USPHS Publication No. 263, Sec. 4) is purchasable (\$1.75) from Superintendent of Documents, Washington 25, D. C., or through WRMS.



## New House Legislation

**HR9618—Tax Postponement for Self-Employed to Create Annuities.** (Ray, R—New York, June 21.) Would amend the Internal Revenue Code to permit exclusion from gross income for income tax purposes not in excess of \$1,000 the first year, \$2,000, 2nd year, and \$3,000 per year thereafter for payments to a restricted retirement fund or for premiums under a restricted retirement annuity contract. These amounts would be limited (if smaller) to  $2\frac{1}{2}$  per cent of the taxpayer's earned adjusted gross income from "covered sources" plus 5 per cent of taxpayer's earned adjusted gross income from all other sources. For a "covered individual" (one who receives compensation from an employer or organization of which the taxpayer is a member, contributing to a pension or profit-sharing plan) the excludable amount shall not exceed the lesser of  $2\frac{1}{2}$  per cent of the taxpayer's earned adjusted gross income or \$500 the first year, \$1,000 the second, and \$1,500 per year thereafter.

Special rule: For individuals over 50 years of age and not "covered" the limit on amount excluded shall be increased by an amount equal to 20 per cent of above multiplied by the number of years his age exceeds 50 years but not in excess of 20. After age 70, the additional exclusion provision is not applicable. Provision is made for carrying over a limited amount of unused exclusions. A consent to be taxed according to formula prescribed in the Internal Revenue Code would have to be filed with the commissioner. This incorporates the Jenkins-Keogh theory (see Letter No. 2) but amounts to be excluded are greatly limited. Nine bills identical with HR9618 were introduced by Republican Congressmen of New York: HR9619 (Latham), HR9620 (Bosch), HR9621 (Dorn), HR9622 (Kearney), HR9623 (Keating), HR9624 (St. George), HR9625 (Williams), HR9644 (Miller), and HR9653 (Wainright). To Ways and Means Committee.

## Draft Boards Told to Recheck Residency Deferrals

The National Advisory Committee to Selective Service is concerned because some young physicians, deferred the past 12 months for residencies and internships, are delaying application for commissions. Involved are priority 1 and 2 men and those in

priority 3 who are 31 years or under. These groups, the committee has informed selective service, are most urgently needed to meet calls for this fiscal year to avoid calls on priority 3 men over 31. Adds the committee: "It is essential, with few exceptions, that those who do not apply for commissions should at least have their 2-A classifications terminated." This would make them eligible for immediate induction.

## Dr. Lyman Again Honored

At the 50th Annual meeting of the founding of the National Tuberculosis Association held at Atlantic City, May 16-21, David R. Lyman, M.D. was one of two persons from Connecticut cited for outstanding pioneering efforts in the scientific and social fields of endeavor.

Dr. Lyman pioneered in the development of the sanatorium program in Connecticut and was among the first in promoting medical research in the field of tuberculosis. Of the 167 founders of the National Tuberculosis Association on June 6, 1904 at Atlantic City, Dr. Lyman was among five of the remaining ten founders to be especially honored at the 50th Anniversary meeting. He was the only one of the five who had the distinction of not only being a "founder" of the tuberculosis movement, but was president of the National Tuberculosis Association in 1918-19 and was the recipient of the Trudeau Gold Medal Award in 1943 for outstanding contribution and achievement in the scientific field of tuberculosis. He was one of the early members of the State Tuberculosis Commission in Connecticut.

## Chicago Goes For Fluoridation

Chicago, America's second largest city with a population of 3,620,962 people will fluoridate its city water supply.

On June 16, 1954, the Chicago City Council approved the fluoridation of that city's public water supplies. The program will begin as soon as funds are made available for the purchase of the necessary equipment and material.

When Chicago starts its fluoridation program more than 20,000,000, in more than 964 cities and towns in the United States will be receiving this preventive measure to fight tooth decay.

What are we waiting for, Connecticut?

PUBLIC RELATIONS  
COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford  
James C. Canniff, Torrington  
Morris A. Hankin, New Haven

Harry C. Knight, Middletown  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

TV Health Education Series Inaugurated

A new series of health education programs was inaugurated September 12 from the television studios of WNHC-TV, in New Haven.

Titled "Stay Well," the series is sponsored by the Connecticut TV Committee for Health Education, comprising 21 representatives from 13 statewide official and voluntary health agencies, and four television stations.

The programs are scheduled for 13 consecutive Monday evenings, from 6:00 to 6:15 P. M. The titles of the first three programs in the series were "You and Cancer," "A Trip Through Your Heart," and "Will Power and Arthritis." Other programs in the current series will be concerned with accident prevention and medical and hospital care.

In cooperation with the TV Committee, the State Medical Society will sponsor four of the programs commencing Monday, August 23, and continuing through September 13. The programs will be titled "Your Medical Care Today," "When the Doctor Comes to Your House," "How to Help Your Doctor Help You," and "When the Patient Needs Special Care."

The Connecticut TV Committee for Health Education was formed in July, 1953, to provide the State's television station managements and health agencies with a clearing house for authentic health information programs. Member agencies have pooled their experience in health education to assure the production of an integrated series of programs. Regulations adopted by the Committee prohibit the use of fund raising appeals on any of the programs.

Fairfield County Survey Discloses Most Towns Have Toll-Free Emergency Service

Residents in 19 of the 23 towns in Fairfield County now have access to emergency medical services

through toll-free telephone networks, according to a survey recently completed for the Fairfield County Medical Association by Arnold P. Olson, executive secretary.

Only four towns are not included in the toll-free areas at the present time, Newtown, Ridgefield, Redding and Sherman. Their combined population of 15,000 represents only a small portion of the total county population of approximately 555,000, the survey discloses. It is anticipated that further expansion and modernization of the dial telephone system will soon bring all communities in the county within the toll-free areas.

Emergency medical call plans are sponsored by local medical societies in cooperation with the Fairfield County Medical Association in five major centers of population, Bridgeport, Danbury, Norwalk, Stamford and Greenwich.

"Your Doctor" Film Screened for High School Students

"Your Doctor," the fifteen minute sound film produced by the American Medical Association and RKO-Radio Pictures was recently shown to more than 600 students in four of Connecticut's high schools. The film was shown before an audience of 394 students at the Wilby High School, Waterbury, and was later screened at high schools in Westport, Old Lyme and Newtown.

The film is available for showing before community groups without charge, except for return postage. Organizations desiring to use the film must provide their own sound projector and operator. Physicians who desire to obtain a copy of the film for use as part of a speaking program are requested to reserve it through the office of the State Medical Society as far in advance of the meeting date as possible.



## PHYSICIAN CONTRIBUTIONS TO THE 1954 AMEF CAMPAIGN WILL . . .

- Assure representation of the medical profession in the drive to balance medical school budgets.
- Help reap the full benefits of a system of medical education unparalleled in history.
- Encourage support from industry and other segments of our society.
- Help medical schools to maintain high standards.
- Help preserve academic freedom and maintain America's leadership in medicine.

Your Contribution is Needed

## OBITUARY

**Berkley M. Parmelee, M.D.**

1895 - 1952



Dr. Berkley M. Parmelee, aged fifty-seven, of Bridgeport, Connecticut, died suddenly of a heart ailment in his office on December 23, 1952. At the time of his death Dr. Parmelee was Director and Senior Attending Radiologist at the Bridgeport Hospital.

Dr. Parmelee was born on April 18, 1895 in St. Albans, Vermont. He received his M.D. degree from the University of Vermont Medical School in 1917 and served his internship at the Bridgeport Hospital from 1918 to 1921. During his internship he was commissioned a lieutenant in the United States Army Medical Corps in World War I. He was in general practice in Bridgeport and later had his preceptor training in radiology at Bridgeport Hospital under Dr. Arthur LaField with whom he was associated for several years. Dr. LaField died in 1933. In addition to his office practice Dr. Parmelee had been attending radiologist at the Bridgeport Hospital from 1933 until his death. His latest work at the hospital involved the establishment of a radioisotope laboratory for the treatment of cancer.

Dr. Parmelee was president of the Bridgeport

Medical Society in 1939 and president of the Fairfield County Medical Association in 1943, and chairman of the Section of Radiology of the Connecticut Medical Society. He was a member of the American Roentgen Ray Society, the American Medical Association, a fellow of the American College of Radiology and a diplomate of the American Board of Radiology.

Berkley Parmelee was an extremely able, enthusiastic radiologist. He was one of the pioneers in promoting radiology on the highest scientific plane in relation to both community and hospital. He was quiet by nature, unruffled and deliberate in habit; but, back of this, he inspired confidence both in his fellow physicians and his patients. He enjoyed his family, his friends, and his home in a rural section of Stratford, Connecticut, that took on an appearance of his family farm home in St. Albans, Vermont; and throughout his somewhat shortened life he was a thorough gentleman. It is with great difficulty that we accept his passing for he leaves a void that cannot be filled.

R. H. Lockhart, M.D.

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### Are Reaction Tests Necessary?

The treatment of alcoholism with disulfiram, after a trial of some 5 years, has found many adherents the world over, and some opponents.

The principal feature of this treatment is the fact that the presence of disulfiram (Antabuse; Alcophobin) in the body causes a derangement in the metabolism of alcohol. This manifests itself by provoking a series of symptoms which involve the circulatory system (blood pressure, pulse rate) as well as digestive functions (nausea, vomiting). Thus, a person who has taken disulfiram is unable to drink alcohol without experiencing some distress of the so-called disulfiram-alcohol reaction. The reaction, however, may range in effect from a mild flushing on the skin to collapse and even death.

In spite of the fact that this single property of disulfiram is basic to all treatment of alcoholism with

*(Continued on page 716)*



## FROM OUR EXCHANGES

Rohn et al. believe that cobalt-iron therapy in iron deficiency anemia in infants is an effective therapeutic agent (*Jour. Indiana State Med. Assoc.*, 46:12). While the number of their cases was not large it appears that the administration of cobalt and iron together had significant advantages over the use of iron alone in nearly all cases of iron deficiency anemia in infants and children. In their series of cases they observed no signs of toxicity or side effects in the doses used. They thought it possible that this relative freedom from side effects was due to the absence of certain impurities from the preparations used. (The preparation used was Roncovite supplied by Lloyd Brothers, Inc. Each 0.6 cc. contains 40 mg. of cobalt chloride and 15 mg. of elemental iron as ferrous sulphate. The preparation is essentially free of lead.)

Cobalt appears to be a powerful stimulant to erythropoiesis and to be able to maintain hemoglobin formation near the physiologic level. The authors know of no other agent which will accomplish such an effect.

The therapy used by the authors was approximately equivalent in results to the transfusion of 1½ pints of blood weekly in adults. Their dose was 0.6 cc. of the cobalt-iron preparation used three times daily to infants and children with pure iron deficiency anemia. This dose provided approximately 45 mg. of elemental iron per day as ferrous sulphate.

\* \* \* \*

"The Roentgenogram—Its Place in Pulmonary Dust Disease" is discussed by Johnstone in the February number of *Industrial Medicine and Surgery* (23:2). There seems to be no meeting of minds on the interpretation of the x-ray shadows as found in those workmen exposed to industrial dust. It is too often forgotten that exposure to pure silica produces roentgen changes different from those produced by a mixture of silica with other dusts of high atomic weight such as iron or barium. The mineralogies of the earth mined in various parts of the world differ from each other. The processing of certain silicates alter their chemical nature. It might be added that opinions on x-ray interpretations become biased when experience is limited to one type of industry or is confined solely to miners in one given area.

X-ray interpretation of the pulmonary dust disease

is best done by the physician who is able to combine equally clinical experience with that of studying the x-ray films. The author concludes that it takes a heap of clinical experience to appreciate the significance of roentgen changes in the pulmonary dust diseases.

\* \* \* \*

"Anxiety" states is a fairly constant problem in the every day practice of medicine. Luton (*Jour. Tenn. State Med. Assoc.*, 46:12) considers that "anxiety states" or reactions are common to some kind of threat to the integrity of the personality. It may come from without or within. The background for the "anxiety state" must be learned from a study of the experiences of the patient from the family setting to the period of the onset of the illness. Treatment should be directed along lines of ventilation, reassurance, suggestion, reeducation and explanation. Physical factors must be sought for and treated.

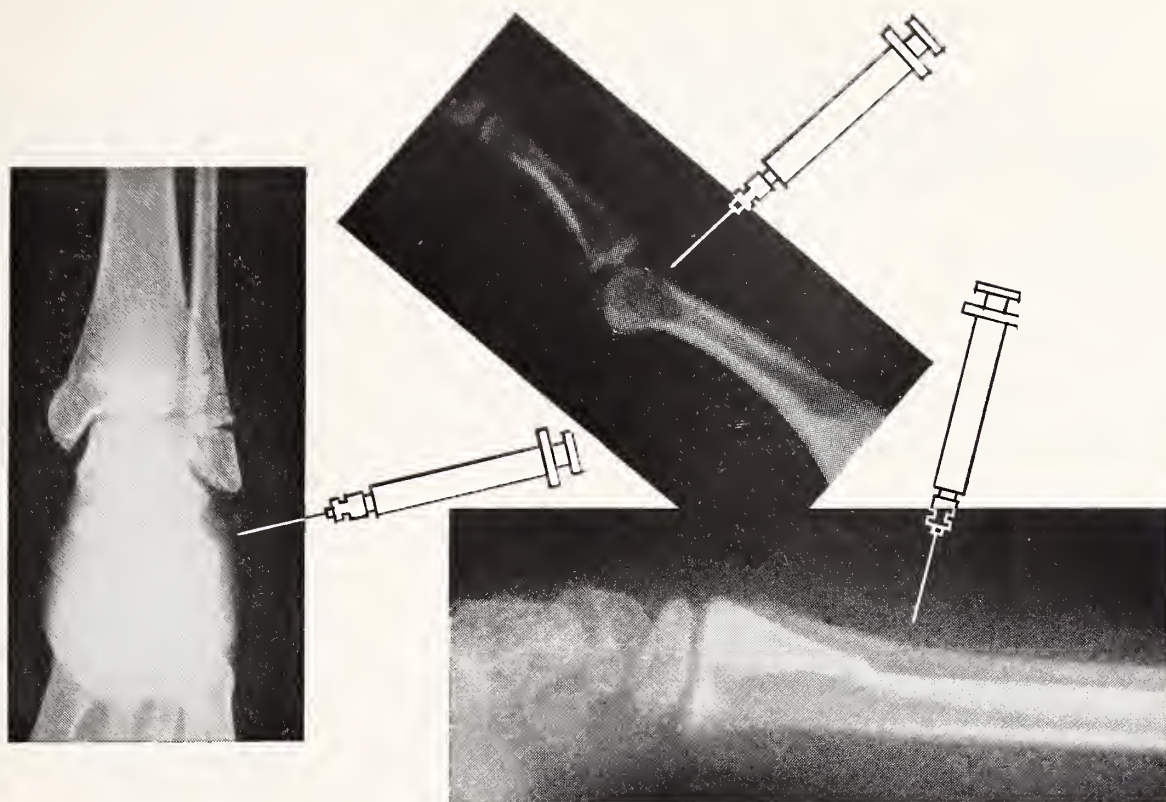
\* \* \* \*

Steadman is of the opinion that an adequate amount of immune globulin should be allotted for the experimental treatment of infectious mononucleosis (*Jour. Tenn. Med. Assoc.*, 46:12). He presents a small series of cases of infectious mononucleosis which seem to show an improvement and to suggest that immune globulin of the current pool is effective as a therapeutic agent in the treatment of infectious mononucleosis. In the author's experience the earlier the immune globulin is given in the course of the disease, the more effective it is.

\* \* \* \*

Pyloric obstruction in peptic ulcer is usually due to a narrowing, which in some cases is in the duodenum instead of at the pylorus (Roth and Liebowitz, *Ann. Int. Med.*, 40:1). Fifty patients were operated on for persistence or recurrence of gastric retention. Thirty-eight were found to have definite narrowing in either the duodenum or pylorus. Active ulcers were present in almost half the cases in spite of previous medical therapy. Obstruction often appeared to be due to the effect of an active ulcer on a duodenum or pylorus narrowed by previous scarring.

In all, 83 patients with peptic ulcer and gastric retention were reviewed. The retention usually



## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery<sup>1</sup> where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means<sup>1,2</sup> of accelerating dispersion of accumulated fluids.*

Swenson<sup>2</sup> has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.



cleared within a week of institution of medical treatment in patients who did not have a recurrence, whereas a longer period was often required in those that later had a recurrence. The clinical history and laboratory findings often indicated whether the patient was likely to be relieved by medical therapy. The patients that came to operation on their first or subsequent admission and had organic obstruction, characteristically were older, had a longer history of ulcer, had more complications, had vomited a longer time and more regularly, had vomited larger quantities, and had often brought up retained food. The laboratory evidence, retention of barium by x-ray and gastric residue of aspiration were usually greater.

### ARE REACTION TESTS NECESSARY

(Continued from page 713)

this drug, it has been employed in two distinct ways: (1) As a conditioning agent, in the same way as nauseant drugs such as emetine or apomorphine are used. In this form of therapy the patient is exposed to a series of reaction tests during which measured amounts of alcohol are given to him. (2) As a means of "chemical internment." In this form of therapy a reaction is usually induced only once. Its purpose is for the patient to learn, through actual physical experience, how dangerous it will be for him to drink while he is under treatment with disulfiram. The conscious fear of the reaction, as experienced under controlled circumstances in the hospital or the doctor's office, is expected to keep the patient from drinking in moments of sudden temptation.

Among those who believe that just one reaction test should be induced, opinions again differ as to the most effective way of creating the conscious fear of the reaction without exposing the patient to an overly severe and possibly dangerous test. Certain physical conditions (particularly cardio-vascular abnormalities) have been considered as contra-indicating treatment with disulfiram. A number of alcoholics have therefore been excluded from the possible advantages of disulfiram treatment. M. Crahan (Los Angeles) has nevertheless given disulfiram to a group of such patients but without inducing any alcohol reaction test in them. Instead

they were permitted to watch others undergoing the reaction. This method was apparently effective in all these patients.

On the whole, the trend has been toward lower dosages both of disulfiram and of the amount of alcohol given for the reaction, and toward keeping the severity of the reaction at a minimum. J. D. Markham and E. C. Hoff (Richmond, Va.) produce a reaction just sufficient for the patient to recognize what is happening. The final development in this trend is illustrated by the method of J. D. Armstrong (Ontario). He gives the patients disulfiram along with information and strong warning as to what happens when alcohol is drunk by those taking this medication, but does not subject the patients to even one trial reaction. He states, "We are of the opinion that this test is unnecessary now that there is clear information available which can be passed on to the patient."

The American Medical Association, while advising extreme caution in inducing the reaction, does not advocate omission of the test. It recommends low maintenance dosages of the drug so that only flushing of the face will occur in a reaction after the drinking of about half an ounce of whisky. The Alcoholism Subcommittee of the World Health Organization likewise advises that an alcohol test should be made, but not repeated. It points to some indication that continued repetition of the reaction may bring about cardiac damage.

*Reprinted from The Connecticut Review on Alcoholism by permission of the executive director of The Connecticut Commission on Alcoholism.*

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- World Health Organization, Expert Committee on Mental Health, Alcoholism Subcommittee. Second Report. World Health Org. Techn. Rep. Ser., No. 48. Geneva; 1952.

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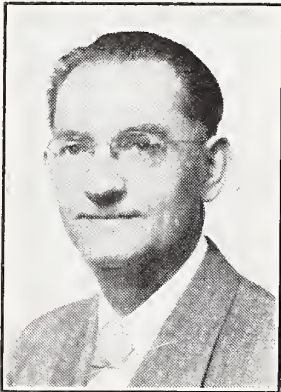
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## SPECIAL NOTICES

### LECTURES ON OCCUPATIONAL MEDICINE

The Faculty of Medicine, Columbia University, announces a series of lectures on Occupational Medicine to be given from nine to ten o'clock on Saturday mornings beginning on September 18, 1954. The lectures will be given in Amphitheater I, College of Physicians and Surgeons, 630 West 168th Street, New York 32, N. Y. The lecturers will be members of the staff of the Division of Occupational Medicine of the School of Public Health.

Interested members of the medical and allied professions are invited to attend. There will be no formal registration and no tuition fee. The schedule is as follows:

September 18—History, scope, objectives and practice of occupational medicine.

September 25—Industrial toxicology—general principles.

October 2—Toxic Metals I.

October 9—Toxic Metals II.

October 16—Toxic Solvents I.

October 23—Toxic Solvents II.

October 30—Toxic Dusts.

November 6—Toxic Gases.

November 13—Ventilation, lighting, noise.

November 20—Elementary nuclear physics; radiation hazards.

November 27—Written examination (optional for visitors).

The order in which the topics are presented may be slightly modified depending on the availability of lecturers.

### ANNUAL MEETING VERMONT STATE MEDICAL SOCIETY OCTOBER 3-4-5, 1954

The 141st annual meeting of the Vermont State Medical Society will be held, for the fifth consecutive year, in conjunction with the New Hampshire Medical Society at the Mt. Washington Hotel, Bretton Woods, N. H., on October 3, 4, and 5, 1954.

General Session speakers: Lewis Dexter, M.D., Boston; Charles G. Child, III, M.D., Boston; Thomas Hale Ham, M.D., Cleveland; Pearce Bailey, M.D., Washington; George F. Wilkin, M.D., Boston.

Sectional speakers: Internal Medicine—Professor Herbert A. Carroll, University of New Hampshire; Lewis Dexter, M.D., Boston. Surgery—C. Stuart Welch, M.D., Albany.

Specialty meetings will be held on Tuesday, October 5, in anesthesiology, dermatology, EENT, general practice, OB-GYN, orthopedics, pediatrics, radiology, pathology, psychiatry, and urology. Most of these programs are designed in the particular specialty for the individual in the general practice of medicine.

### POSTGRADUATE COURSES IN DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective State chapters of the College as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Ninth Annual Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, Illinois, October 18-22, 1954, and the Seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Hotel New Yorker, New York City, November 8-12, 1954.

These annual postgraduate courses endeavor to bring physicians up to date on recent advancements in the diagnosis and treatment of heart and lung diseases. Tuition for each course is \$75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

### PRELIMINARY PROGRAM THIRD INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST

Barcelona, Spain, October 4-8, 1954

Sponsored by Council on International Affairs, American College of Chest Physicians, under the patronage of the Spanish Government.

Leading specialists in cardiac and pulmonary diseases throughout the world will participate in scientific discussions dealing with recent advances made in the diagnosis and treatment of heart and lung diseases. Delegations of chest specialists from all countries will be present in Barcelona for this important Congress and all physicians interested in diseases of the chest are cordially invited to attend. The official languages for the Congress are Spanish, French, German and English. For further information please communicate with the Secretary General, Professor Anthony Caralps, Corcega 393, Barcelona, Spain.

### RHODE ISLAND MEDICAL SOCIETY PRIZE

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Modern Developments in Anesthesia." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

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## THE AMERICAN GERIATRICS SOCIETY

In keeping with the objectives of the Society to make readily available to the medical profession knowledge of the latest clinical practices having to do with this broad field The American Geriatrics Society will give a Graduate Symposium on Geriatric Medicine at the Roosevelt Hotel, New York City, November 12 and 13, 1954.

This is a service provided by the Society for its Fellows and all members of the medical profession.

Distinguished specialists from our leading medical schools and teaching hospitals will conduct the symposium.

We cordially invite all interested physicians to attend this important symposium.

There will be no registration fee.



## SIXTH AMERICAN CONGRESS FOR OBSTETRICS AND GYNECOLOGY IN DECEMBER

The American Committee on Maternal Welfare and the American Academy of Obstetrics and Gynecology have joined forces to co-sponsor a unique five day conference for physicians, nurses, public health officials and hospital administrators. The Sixth American Congress on Obstetrics and Gynecology will convene at the Palmer House in Chicago, December 13 through 17.

The Congress will offer a comprehensive program of panel discussions, round tables, symposia and formal presentations.

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## NEWS

### *from County Associations*

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#### Fairfield

A Committee on Local Arrangements for the annual meeting of the Connecticut State Medical Society which will be held at the Stratford High School in Stratford on April 26, 27, and 28, 1955 was recently appointed by the Board of Trustees of the Fairfield County Medical Association. The committee consists of Edwin R. Connors, secretary of the Fairfield County Medical Association as chairman, Nathan H. Friedman, Sidney L. Penner, Nicholas P. R. Spinelli, Daniel Barker, Stuart L. Joslin and Mr. Arnold P. Olson, executive secretary of the Fairfield County Medical Association. The annual banquet of the Society will be held at the Stratfield Hotel in Bridgeport on April 27, 1955.

The Annual Scientific Assembly of the Connecticut Academy of General Practice will take place on October 20 at the Stratfield Hotel in Bridgeport. It will consist of six lectures in morning and afternoon sessions and dinner at night. Members and their wives will be guests of the Academy at lunch in the Stratfield and a card party will be held for the wives in the afternoon.

D. Olan Meeker of Riverside was elected to membership in the American Proctologic Society on June 9 at the annual meeting of the Society held in Los Angeles. Dr. Meeker was elected a member of the New England Proctologic Association at a meeting of the Association held in Waterbury on May 8.

The Fairfield County Medical Golf Association held a tournament at the Mill River Country Club in

Stratford on June 23 and the July tournament at the New Canaan Country Club on July 21.

Kurt A. Oster of Bridgeport has contributed two chapters to the textbook, "Antiseptics, Disinfectants, Fungicides, and Chemical and Physical Sterilization," edited by Dr. G. F. Reddish and published by Lee and Febiger, entitled, "Fungistatic and Fungicidal Test Methods," and "Fungistatic and Fungicidal Compounds."

The Annual Golf Outing of the Bridgeport Medical Association was held at the Long Shore Country Club in Westport on the afternoon of July 7. The highlight of the outing was the tournament between the Bridgeport Hospital team consisting of C. Fred Yeager, Paul Harwood, Edward F. Trautman, Edward P. McCreary and Colman Lopatin and the St. Vincent's Hospital team composed of Ralph L. Parker, John Gulash, Michael C. Luciano, Joseph Chiota and Leonard Scalzi. The Bridgeport Hospital team were the victors. C. Fred Yeager won low gross honors with Paul H. Harwood and Ralph Parker runners-up. Roland T. Wehger was the victor in the handicap division with Edwin F. Trautman runner-up. The president of the Association, John F. Nolan, with his new bride also participated in the tournament.

#### Hartford

The Public Relations Committee is now clearing a new survey which will undertake to determine medical needs in the community.

Sometime in the early part of July, Hartford County Medical Association physicians received a Blue Cross questionnaire asking whether they would be interested in their new higher benefit comprehensive plan. In order to make this plan operative for Hartford County Medical Association's present group, 75 per cent of the entire membership will have to subscribe (about 600 members).

Recently Alfred L. Burgdorf, director of the Hartford Health Department, spoke to the Women's Auxiliary of Hartford Hospital on "Community Patterns for Health."

Curtiss B. Hickcox, deputy chairman of the Department of Anesthesiology at Hartford Hospital and secretary-treasurer of the American Board of Anesthesiology, served as an examiner during the Board's semi-annual meeting in New Orleans.

The Connecticut Veterans' Administration Medical Society consisting of the Hartford and Bridge-

port Regional offices recently elected Julius Sachs, president, Paul M. Sherwood, vice-president and Joseph Brandriss, treasurer.

Andrew J. Canzonetti of New Britain has returned to practice after serving 18 months in Korea. Dr. Canzonetti was Assistant Chief of Surgery on the hospital ship, Haven, and Chief of Surgery at the New London Submarine Base.

Three chest specialists, Francis D. T. Bowen, William A. Goodrich and James J. Hennessey, have begun reading some 6,000 chest x-rays taken by the Greater Hartford Tuberculosis and Public Health Society.

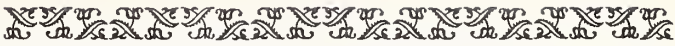
Charles W. Goff spoke to the Hartford Anthropological Society last month on "The Cultural and Historical Determinants of Syphilis" and outlined in detail the history and treatments of this disease up to the present.

In a three week trip this last month William B. Scoville, Hartford neurosurgeon, attended the American Academy of Neurology meetings in Washington, the American Psychiatric Association in St. Louis, the Harvey Cushing Society in Santa Fe, and a lobotomy symposium in Cincinnati.

The medical staff of New Britain Memorial Hospital has reelected Dwight J. Bernstein, president. Dr. Bernstein is a graduate of the University of Vermont, College of Medicine. He is a member of the pediatric staff at New Britain General.

First plans for housing the Hartford County Medical Association in the proposed new building at Scarborough Street were submitted to the Association's housing committee for consideration this month by the Hartford Medical Society. Architect's plans for the executive offices call for 1,500 square feet on the second floor over the superintendent's quarters just in back of the auditorium. The executive offices will include an executive secretary's office, a secretary's office, an outer office for personnel, files and equipment, a store room and a large room for a switchboard telephone. Benjamin Salvin, chairman of the County's Housing Committee, said that the architect's plans meet with the committee's approval. He said that final approval of location and cost would be up to the Board of Directors. Other members of this Housing Committee are: Amos E. Friend of Manchester, Thomas M. Feeney, Burdette J. Buck, and Ralph T. Ogden of Hartford, Martin I. Hall of Bristol and Harold M. Clarke of New Britain.

New appointments to the Committee on Industrial Health were announced last month by Amos E.



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Friend, president. They are: Roland Z. Carignan, chairman; Robert R. Keeney, Jr., Bernard S. Dignam, Francis J. Ryan, Harvey H. Sirota, Alfred B. Sundquist, Vincent J. Turco, William H. Horton, Thomas F. LaPorte and William Livingstone.

Added to the Committee on Public Relations are: Burdette J. Buck, chairman; Harold J. Lehmus and Dwight J. Bernstein.

Appointed to the Committee on Medical Ethics and Department are: D. Dillon Reidy, chairman; Dewey Katz and Charles W. Goff. Other members are: Howard J. Lockwood, Martin I. Hall, Wilson F. Smith, Amos E. Friend, Thomas M. Feeney and Philip M. Cornwell.

Delegates to other county associations are: Henry Kraszewski to Fairfield; Harold B. Woodward to Litchfield; Charles Tucker to Middlesex; Timothy Curran to New Haven; Gerard Miller to New London; Walter M. Schardt to Tolland; and Robert R. Keeney, Jr., to Windham County.

## Middlesex

A former intern at Middlesex Memorial Hospital is coming back to Middletown to go into private practice. After finishing his tour of duty here, Andrew Turano spent the past two years as a resident in pediatrics at University Hospital in New York. He is going to limit his practice to pediatrics.

Another newcomer to town is William Sweeney. He is going to join G. M. Craig, C. B. Crampton and A. W. Thomson in the practice of obstetrics and gynecology.

Marie Lindsay, who has been in charge of one of the female services at the Connecticut State Hospital, retired at the end of June.

Following the resignation of Hazen Calhoun, the following men were appointed as medical examiners: Norman Rindge for the town of Killingworth and A. B. Rafkind for the town of Haddam.

Francis Korn, who has been practicing general medicine in Durham for the past several years, has taken a residency in roentgenology at New Haven Hospital. He will continue to see patients by appointment.

## New London

Walter McKeand Brown, M.D. announces the opening of his office at 295 Long Hill Road, Groton. Practice limited to obstetrics and gynecology.

Hugh Lena and Paul Gerity recently successfully completed part two of American Board in Surgery.

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The monthly dinner lecture meeting of the Lawrence and Memorial Hospital was held June 17. The speaker, Bertram Selverston, professor of neurosurgery, Tufts College Medical School, neurosurgeon in chief, New England Center Hospital, spoke on "Epilepsy in the Adult."

On June 28 at the annual dinner meeting of the New London Heart Chapter, Richard Starr, M.D. was elected president and Harold Irwin, M.D., vice-president. Past president Hilliard Spitz was praised in the accomplishment of the chapter in the past year. The organization is presently sponsoring a program to obtain penicillin to be given prophylactically to children suffering from rheumatic fever.

Charles Pfizer & Company was host to about 70 members of the New London County Medical Association June 23 at the Pfizer clubhouse following the third annual golf tournament at the Shenecossett Country Club. During a buffet dinner at the clubhouse, Walter L. Elwood, Jr., superintendent of the Groton plant, presented awards to 13 Association members for various accomplishments in the tournament. Recipients were Fred J. Fagan, Louis P. DeAngelis, Joseph C. Woodward, John F. Brosnan, Louis P. Saxe, and Fred W. Goodrich. Also S. Paul Tombari of Waterford; Mario J. Albamonti, Robert D. Hayes, David G. Rousseau and Casmir E. Bielecki of Norwich; John A. Celestino and Paul R. Kelly of Westerly. The committee in charge included John Boland of Manchester, district sales manager, and Edward McCann and Robert Geisler, sales representatives.

It has been announced by Sister M. Emmanuel, administratrix of the new Marian Hospital, that this institution at 154 Broad Street, New London will be opened in the very near future. It will be under the direction of the Daughters of Mary of the Immaculate Conception and is for the care of people of all faiths and creeds. All doctors interested in joining the staff are requested to file applications.

## NEW BOOKS IN REVIEW

*THE MEANING OF SOCIAL MEDICINE.* By Iago Galdston, M.D., Secretary Medical Information Bureau, The New York Academy of Medicine. Cambridge, Mass.: Harvard University Press. 1954. 137 pp. \$2.75.

Reviewed by STANLEY B. WELD

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one should read it at a single sitting. It will be two hours well spent. Only five years ago the same author collected a series of lectures delivered at the Institute on Social Medicine in connection with the Centennial Celebration of the New York Academy of Medicine and published them under the title, "Social Medicine, Its Derivations and Objectives."

In the present volume the author has condensed and continued much of the discussion of these several authors, adding his personal convictions after a visit to England and one to the Continent. Just what is social medicine and how it differs from socialized medicine is the theme of the book. Emphasis is placed on the concept of attention to the medical needs of the individual in his social environment, not only when ill with some disease but before illness has struck. Herein lies the difference between social medicine and curative medicine and even preventive medicine as the latter term is generally understood today.

An entire chapter is used to point out how modern medicine has failed. Social medicine is concerned, not only with one's disease, but with what had happened and was happening with and to the man so that he became manifestly ill and what must be done to really effect a cure.

There is a chapter on the Epidemic Constitution with pertinent examples taken from the influenza pandemic of 1918-1919. Attention is called to the increasing expectancy of life, lowered mortality rates, and accompanying increase in the problem of the chronically ill.

Finally, the author proposes an entire revision of the medical school curriculum, placing the emphasis on life and its fulfillment rather than on death and disease. "Medical education," to quote Dr. Galdston, "envisaged in the gestalt of social medicine would include all the knowledge now taught: anatomy, histology, physiology, bacteriology, diagnosis, therapy, etc. Their orientation, however, would be radically altered. It would not be permissible or possible to perpetrate such illogical affirmations as, for example, that 'tuberculosis is caused by the tubercle bacillus'." . . .

"Medical education as conceived in the gestalt of social medicine will therefore include certain knowledges now but little cultivated in the premedical or undergraduate years. Among such would be: dynamic, as distinct from descriptive, biology and its history; the history of medicine with emphasis on the fundamental ideas which inspired and motivated its different epochs; the sociology of communal life; the elements of anthropology; the elements of individual and group psychology. This curriculum would also include enough of philosophy to enable the student to understand and to deal with the problems of value judgments. For the physician needs must be not only a healer but also a counselor, and this function will be preeminent in social medicine."

Our medical school curricula are in dire need of overhauling. I wonder how these changes suggested by the author will appeal to the deans. Food for thought—and maybe for action!

The volume closes with an addendum on Social Medicine in England, a comparison with socialized medicine in the same country, and some comments from a summary report from conferences on social medicine held in England.

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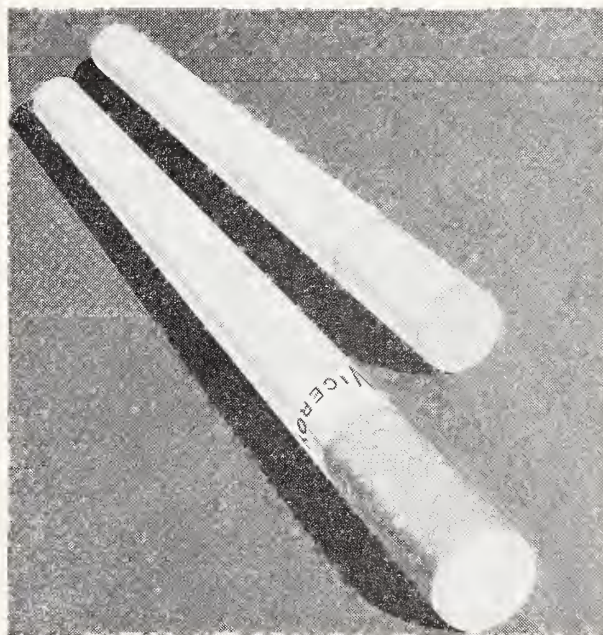


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# CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVIII

SEPTEMBER, 1954

No. 9

## TWENTY-NINTH CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

GRACE-NEW HAVEN COMMUNITY HOSPITAL AND THE MEDICAL SCHOOL  
Cedar Street, New Haven

September 15, 16, 1954

### GENERAL INFORMATION

#### REGISTRATION FEE

The registration for members of the Connecticut State Medical Society is \$3. The fee for persons who are not members of the Society is \$4. Payment of the registration fee provides for admission to all sessions of the Congress.

Hospital residents, interns, and medical students will be admitted to all sessions without charge, if a statement of their position, signed by an official of the hospital or medical school, is presented at the registration desk.

#### MEETING PLACE

All of the sessions will be held in Brady Auditorium, Farnum and Fitkin Amphitheaters, at the School of Medicine and New Haven Hospital. Three sessions will be held simultaneously giving a broad selection of topics.

#### TELEPHONE

Telephone messages will be received at New Haven LO 2-1161.

#### LUNCHEON

Cafeteria luncheon will be served at the Memorial Unit on the two days of the Congress.

#### PARKING

There are public parking areas near the hospital and metered curb parking. Automobile stickers will be provided for all registrants.

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The Connecticut Chapter of the American Academy of Pediatrics will hold a social hour and dinner, beginning at 6:00 P. M., at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Wednesday, September 15. Annual business meeting to follow.

Members of the Hezekiah Beardsley Pediatric Club are cordially invited to be present at the social hour and dinner. Reservations for dinner must be made in advance by mailing check for \$4 to dinner chairman: Paul McAlenney, M.D., 250 Edwards Street, New Haven.



## PROGRAM

## TWENTY-NINTH CONNECTICUT CLINICAL CONGRESS

WEDNESDAY, SEPTEMBER 15, 1954

## MORNING SESSIONS

9:30 REGISTRATION

## BRADY AUDITORIUM

Bliss B. Clark, *New Britain, presiding*

- 10:00 THE SURGICAL MANAGEMENT OF VARICOSE VEINS, VARICOSE ULCER, AND THE POSTPHLEBITIC LEG  
Charles V. Menendez, *Brookline; Clinical Assistant in Surgery, Massachusetts General Hospital*
- 10:45 GASTROINTESTINAL COMPLICATIONS OF ANTIBIOTIC THERAPY  
Chester W. Fairlie, *Hartford; Assistant Clinical Professor of Medicine, Yale University School of Medicine; Clinical Assistant in Medicine, Hartford Hospital*
- 11:30 PROBLEMS ASSOCIATED WITH THE DIAGNOSIS AND TREATMENT OF HERMAPHRODITISM IN CHILDREN  
Nicholas M. Stahl, *Boston; Instructor in Surgery, Harvard Medical School; Associate Surgeon, Children's Hospital, Boston*

## FARNUM AMPHITHEATER

Hugh K. Miller, *Stamford, presiding*

- 10:00 CERVICAL PATHOLOGY IN STERILITY PROBLEMS  
Lee Buxton, *New Haven; Professor and Chairman of Department of Obstetrics and Gynecology, Yale University School of Medicine*
- 10:45 THE USE OF PITUITARY EXTRACT IN THE CONDUCT OF LABOR  
D. Anthony D'Esopo, *New York; Professor of Clinical Obstetrics and Gynecology, Columbia College of Physicians and Surgeons; Attending Obstetrician and Gynecologist, Columbia Presbyterian Medical Center*
- 11:30 ENDOCRINE ASPECTS OF INFERTILITY  
Somers Hayes Sturgis, *Boston; Associate Clinical Professor of Gynecology, Harvard Medical School; Surgeon (Gynecology), Peter Bent Brigham Hospital*

## FITKIN AMPHITHEATER

Benjamin V. White, *Hartford, presiding*

- 10:00 PRINCIPLES OF ANTIBIOTIC THERAPY—CHOICE OF TREATMENT  
Paul B. Beeson, *New Haven; Professor of Medicine, Yale University Medical School; Physician-in-Chief, University Service, Grace-New Haven Community Hospital*
- 10:45 SOME PRINCIPLES OF ANTIBIOTIC THERAPY—THE CLINICAL RESPONSE  
Ivan L. Bennett, Jr., *Baltimore; Associate Professor of Medicine, Johns Hopkins Medical School; Physician, Johns Hopkins Hospital*
- 11:30 DRUG RESISTANCE AND ITS CLINICAL IMPLICATIONS  
Harry Eagle, *Bethesda; Public Health Service, National Institutes of Health*

12:30 LUNCHEON — Memorial Unit

## WEDNESDAY, SEPTEMBER 15, 1954

## AFTERNOON SESSIONS

## BRADY AUDITORIUM

Gustaf E. Lindskog, *New Haven, presiding*

## 2:00 CARDIAC ARREST, INCLUDING AN APPRAISAL OF THE MECHANICAL DEVICES FOR TREATMENT

Julian Johnson, *Philadelphia; Professor of Surgery, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Associate Surgeon, Hospital of the University of Pennsylvania*

## 2:45 SURGERY OF THE URETER, PLANNED AND ACCIDENTAL

Willet F. Whitmore, Jr., *New York; Associate Professor Clinical Surgery (Urology), Cornell University Medical College; Attending Surgeon (Urology), Memorial Center, New York*

## 3:30 THE SURGICAL TREATMENT OF MITRAL STENOSIS

William W. L. Glenn, *New Haven; Associate Professor of Surgery, Yale University School of Medicine; Attending Surgeon, Grace-New Haven Community Hospital*

## FARNUM AMPHITHEATER

Oliver L. Stringfield, *Stamford, presiding*

## 2:00 ERYTHROBLASTOSIS AND JAUNDICE IN INFANCY

David Yi-Yung Hsia, *Boston; Instructor in Pediatrics, Harvard Medical School; Assistant Physician, Children's Medical Center, Boston*

## 2:45 BEHAVIOR PROBLEMS IN ADOLESCENCE

Felix P. Heald, *Boston; Instructor in Pediatrics, Harvard Medical School; Assistant Physician in Adolescent Unit, Children's Medical Center, Boston*

## 3:30 RECENT ADVANCES IN THE MANAGEMENT OF CERTAIN INFECTIOUS DISEASES

William L. Bradford, *Rochester; Professor of Pediatrics, University of Rochester School of Medicine; Pediatrician-in-Chief, Strong Memorial Hospital*

## FITKIN AMPHITHEATER

Gideon K. deForest, *New Haven, presiding*

## 2:00 THE DIFFERENTIAL DIAGNOSIS OF JOINT PAINS

Marian W. Ropes, *Winchester; Associate Physician, Massachusetts General Hospital; Assistant Clinical Professor of Medicine, Harvard Medical School*

## 2:45 OBSERVATIONS REGARDING NONHORMONE THERAPY FOR ARTHRITIS

Richard H. Freyberg, *New York; Associate Professor of Clinical Medicine, Cornell University Medical College; Director of the Department of Internal Medicine, Hospital for Special Surgery, New York*

## 3:30 THE MANAGEMENT OF RHEUMATOID ARTHRITIS

Charles Ragan, *New York; Associate Professor of Medicine, Columbia University, College of Physicians and Surgeons; Associate Attending Physician, Presbyterian Hospital, New York*



## THURSDAY, SEPTEMBER 16, 1954

## MORNING SESSIONS

9:30 REGISTRATION

## BRADY AUDITORIUM

John C. White, *New Britain, presiding*

## 10:00 THE SURGICAL TREATMENT OF INTRACTABLE ANGINA

Samuel Alcott Thompson, *New York; Associate Professor of Surgery, New York Medical College; Attending Surgeon, Flower and Fifth Avenue Hospital*

## 10:45 ACUTE PERICARDITIS

Morton G. Brown, *Boston; Associate Clinical Professor of Medicine, Tufts College Medical School*

## 11:30 OPERATIONS FOR CORONARY ARTERY DISEASE

Claude S. Beck, *Cleveland; Professor, Cardiovascular Surgery, Western Reserve University; Associate Surgeon, University Hospitals, in charge of cardiovascular surgery*

## FARNUM AMPHITHEATER

Samuel D. Kushlan, *New Haven, presiding*

## 10:00 THE CHOICE OF SURGERY FOR DUODENAL ULCER

John R. Brooks, *Boston; Associate in Surgery, Peter Bent Brigham Hospital; Instructor in Surgery, Harvard Medical School*

## 10:45 ACUTE UPPER GASTROINTESTINAL HEMORRHAGE—EARLY USE OF DIAGNOSTIC TECHNIQS

Norman M. Scott, Jr., *Major MC—USA, Walter Reed Army Hospital, Washington, D. C. (Prepared in collaboration with Eddy D. Palmer, Lt. Col., MC—USA)*

## 11:30 PANCREATITIS

Marshall K. Bartlett, *Boston; Clinical Associate in Surgery, Harvard Medical School; Visiting Surgeon, Massachusetts General Hospital*

## FITKIN AMPHITHEATER

Edward J. Ottenheimer, *Willimantic, presiding*

## 10:00 THYROIDITIS

George Crile, Jr., *Cleveland; Surgeon, Cleveland Clinic Hospital*

## 10:45 INDICATIONS FOR THYROID SURGERY

Oliver Cope, *Boston; Associate Professor of Surgery, Harvard Medical School; Visiting Surgeon, Massachusetts General Hospital*

## 11:30 RADIOIODINE TREATMENT OF THYROID DISEASE

Sidney C. Werner, *New York; Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons; Associate Attending Physician, Presbyterian Hospital, New York*

12:30 LUNCHEON — Memorial Unit

## THURSDAY, SEPTEMBER 16, 1954

## AFTERNOON SESSIONS

## BRADY AUDITORIUM

Clifford D. Moore, *Stamford, presiding*

## 2:00 DIAGNOSIS AND TREATMENT OF OPIATE AND BARBITURATE ADDICTIONS

Abraham Wikler, *Lexington; Assistant Professor of Psychiatry, University of Cincinnati College of Medicine; Chief, Neuropsychiatric Section, NIMH Addiction Research Center, Lexington, Kentucky*

## 2:45 THE USE OF DISULFIRAM (ANTABUSE) IN THE COMPREHENSIVE THERAPY OF A GROUP OF 1,200 ALCOHOLICS

Ebbe Curtis Hoff, PH.D., M.D., *Richmond; Professor of Neurological Science, Medical College of Virginia; Medical Director, Division of Alcohol Studies and Rehabilitation, State Department of Health, Commonwealth of Virginia*

## 3:30 THE MEDICAL ASPECTS OF ALCOHOLISM

Maurice Victor, *Boston; Instructor in Neurology, Harvard Medical School; Assistant Neurologist, Massachusetts General Hospital*

## FARNUM AMPHITHEATER

Luther M. Strayer, Jr., *Bridgeport, presiding*

## 2:00 THE LOCAL TREATMENT OF SEVERE BURNS

Gervase J. Connor, *New Haven; Attending Surgeon, St. Raphael's Hospital; Attending Surgeon, Grace-New Haven Community Hospital*

## 2:45 SALVAGING THE INJURED HAND

William H. Frackelton, *Milwaukee; Assistant Professor of Surgery, Marquette University Medical School; Senior Staff, Division of Plastic Surgery, Columbia Hospital, Milwaukee*

## 3:30 THE MANAGEMENT OF TRAUMATIC SWELLING, OLD AND NEW METHODS

Thomas W. Stevenson, *New York; Professor of Clinical Surgery, Columbia University, College of Physicians and Surgeons; Attending Surgeon, Presbyterian Hospital*

A DINNER WILL BE HELD AT THE GRADUATES CLUB, NEW HAVEN, AT 6:00 P. M. FOR PERSONS INTERESTED IN THE SURGERY OF TRAUMA. RESERVATIONS SHOULD BE MADE WITH LUTHER M. STRAYER, JR., 144 GOLDEN HILL STREET, BRIDGEPORT; OR WILLIAM S. PERHAM, 369 EDWARDS STREET, NEW HAVEN, BY SEPTEMBER 7

## FITKIN AMPHITHEATER

Ettore F. Carniglia, *Hartford, presiding*

## 2:00 CEREBRAL VASCULAR ACCIDENT—THE DIFFERENTIAL DIAGNOSIS

H. Houston Merritt, *New York; Professor of Neurology, Columbia University, College of Physicians and Surgeons; Director of Service of Neurology, Neurological Institute, Presbyterian Hospital, New York*

## 2:45 THE SYNDROMES OF PROGRESSIVE OCCLUSION OF CAROTID AND BASILAR ARTERIES

Joseph M. Foley, *Boston; Assistant Professor of Neurology, Harvard Medical School; Assistant Visiting Neurologist, Boston City Hospital*

## 3:30 DIFFERENTIAL DIAGNOSIS OF SYNCOPE

Adrian M. Ostfeld, *New York; Research Fellow in Medicine, Cornell Medical College; Provisional Assistant Physician, New York Hospital*



## NO ANATOMIC CAUSE OF DEATH

THE forensic ("medicolegal") pathologist surveys and studies an autopsy population which is different from that processed by his clinical colleague. The clinical pathologist carries out his post-mortem work on patients who have died of natural disease while under medical observation and treatment for greater or lesser periods of time. When a body arrives at a hospital autopsy table it is usually accompanied by a clinical chart with detailed anamnestic, bedside and laboratory data for the guidance and information of the prosector. In almost every case the hospital pathologist can demonstrate gross and microscopic lethal and nonlethal organic changes which illuminate the patient's clinical course.

The forensic pathologist strives also to demonstrate the anatomic equivalent of the clinical syndrome, but he functions in a different anatomic environment. A large proportion of the cases which find their way to the medicolegal autopsy table have died suddenly and unexpectedly while in a state of apparent good health.

Sudden death is always a startling event, producing a severe impact on those who survive. The reactions of humanity to sudden death vary widely. There are those such as doctor and author Axel Munthe who in answer to the question, "What do you regard as life's greatest boon?" replied, "Sudden death with no doctors anywhere around." The majority of mankind, however, probably goes along with the sentiment expressed in the Litany of the Saints and asks to be spared "from a sudden and unprovided death." Added to the grief that inevitably follows such a loss is speculation as to what has actually happened. It is the responsibility of the forensic pathologist to establish the cause of death in these cases.

The cases studied by the forensic pathologist fall into four categories with respect to the degree of certainty with which the cause of death can be established by the autopsy or by a combination of postmortem findings and anamnestic data.<sup>1</sup>

## The Enigma of the Forensic Pathologist

LESTER ADELSON, M.D., *Cleveland*

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The Author. *Assistant Professor of Legal Medicine, Department of Pathology, Western Reserve University School of Medicine; Chief Deputy Coroner, Cuyahoga County, Ohio*

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### SUMMARY

Three groups of cases have been presented in which no real or apparent organic cause of death is seen at autopsy:

1. Fatal poisonings without anatomic changes. These are solved in the forensic chemistry laboratory.

2. Instantaneous physiologic deaths. These are diagnosed by exclusion. They illustrate the problem of disordered function without disordered structure. A history of a precipitating event is essential to establish the entity.

3. Sudden deaths in infancy. These may present no apparent organic cause of death. Microscopic examination often reveals serious disease in the respiratory tract, heart, or brain and thus furnishes a reasonable explanation for the unexpected exitus.

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I. In the first category the postmortem findings are such as to establish beyond doubt the identity of the injury or disease which caused death. It is readily apparent that the lesion or lesions present are incompatible with life and are of antemortem occurrence. The gross autopsy thus promptly clarifies the unanticipated demise. In this category belong such self-evident situations as massive pulmonary thromboembolism or air embolism, massive intracranial hemorrhage, acute thrombotic occlusion of a major coronary artery which had been previously patent, ruptured luetic, arteriosclerotic and dissecting aneurysms and the like. Gross trauma such as disruption of the heart, aorta or brain stem falls into the same category as does obvious fatal poisoning by carbon monoxide with a hemoglobin saturation of 75 per cent.

II. In the second category postmortem examina-

tion discloses the cause of death with a high degree of probability. The changes discovered are not necessarily incompatible with life, but the investigation discloses no other explanation for death and the location and nature of the pathological changes are adequate to account for death. To this category belong such lesions as recent and severe cranial cerebral trauma not involving the brain stem and not associated with massive intracranial bleeding, broncho- or lobar pneumonia sufficiently extensive to be readily recognized on gross examination, advanced heart disease, or a wound which probably resulted in severe blood loss.

III. In the third category the cause of death is established primarily by anamnestic facts which are confirmed or supported to a variable degree by the postmortem findings. Thus, if it is known that the body was recovered from water and if the postmortem examination discloses positive evidence that the water has been inhaled and no other evidence or explanation, it could be reasonably assumed that death resulted from drowning. If death is known to have been preceded by a 48 hour period of coma and if postmortem examination discloses a blood barbiturate level of 2 mgm./100 cc. and no other significant findings, it would be reasonable to conclude that death was due to barbiturate intoxication. From the standpoint of the pathologist the evidence upon which the cause of death is established in this category is less satisfactory than in the two preceding groups inasmuch as the critical facts upon which the diagnosis is based are not of his own acquisition.

IV. In the fourth category neither the anamnestic data nor the postmortem investigation, individually or in combination, provide sufficient evidence to do more than speculate as to the cause of death. Because of the general lay impression that the cause of death is always disclosed by an autopsy, the forensic pathologist may be pressed to make a positive statement despite the absence of adequate evidence. Thus, the discovery of a minute atheromatous plaque in a coronary artery is likely to result in death being attributed to arteriosclerotic heart disease in the case of an otherwise unexplained death in an apparently healthy adult. It would be preferable to take advantage of the classification "Diseases Due to Unknown Causes Without Organic Change" as listed in the Standard Nomenclature of Diseases and Operations for recording the cause of such deaths.

Autopsies which do not reveal a plain cause for death or in which there are trivial, equivocal or even

no positive findings are a source of perplexity to the pathologist who earnestly seeks to establish a real reason for death. Mild degrees of natural disease may be present as the only finding. Meticulous elimination of other possibilities is essential before death can be ascribed to such natural disease. Changes which are the result of the dying process must be fully screened and evaluated lest they be assigned a causative role. Behind every unexpected death lurk innumerable possibilities which may escape detection unless a painstaking and thorough search is made. The task may be of Gordian complexity, but it is not to be solved by intuition or a few strokes of the knife.<sup>2</sup>

It is to those sudden and unexpected or obscure and unwitnessed deaths in which there is no gross or microscopic evidence of disease or trauma that I wish to devote our attention. This puzzling (and occasionally to the pathologist, embarrassing) group of cases deserves discussion if only because they are a constantly recurring problem.

Functioning as a morbid anatomist, the pathologist has relied upon the autopsy as the time honored method to determine the cause of death. He searches for anatomic changes, natural or traumatic, whose presence is incompatible with survival. These lesions he terms the "anatomic cause of death." Where no such lesions are present, he must turn elsewhere for his answer.

Consider the following rather common situation in forensic practice. An unattended dead body is found. At the time of autopsy no witnesses or data are available. The circumstances preceding death are not known. Complete autopsy yields anatomic findings which are important only in their negativity or nonspecificity. What possibilities present themselves as potential solutions to the pathologist confronted by such a dilemma?

#### DEATH BY POISON

Where significant organic changes are scant or nonexistent, death by poison ranks high on the index of suspicion of the forensic pathologist. Five per cent of all deaths which come to the attention of official medicolegal investigating agencies result from exogenous toxic substances. Homicidal poisoning which bulks so large in the lay mind is actually responsible for less than 1 per cent of fatal poisonings. Suicide and accident each account for approximately half of the fatalities due to poison. Statistics from the Cuyahoga County Coroner's Office, which



serves Cleveland and the neighboring area, indicate that one-fourth of all suicides, one-third of all accidents (excluding vehicular mishaps) and less than 1 per cent of all homicides are due to poisons.<sup>3</sup> In a population of 1.5 million there are 75 fatal poisonings annually. The same ratio probably holds true in the metropolitan areas of Connecticut. Deaths due to poison are not rare.

There are common poisons which produce striking and even characteristic anatomic changes readily recognized at autopsy. Such are the cherry-red color of acute carbon monoxide asphyxia and the gastrointestinal damage produced by heavy metal and corrosive poisons. Occasionally where visual anatomic changes tell little or nothing, olfactory exploration may be valuable. The odor of bitter almonds in death from a cyanide, the aromatic odor of oil of wintergreen in methyl salicylate intoxication or the reek of kerosene in insecticide sprays which contain DDT can alert the pathologist to the true state of affairs.

#### CASE

A twenty-five year old woman was found in her apartment in a state of moderate postmortem decomposition after not having been seen for several days. When the body was opened at autopsy, the characteristic odor of bitter almonds was perceptible despite the stench of putrefaction. Chemical tests of the blood and stomach content were strongly positive for cyanide.

#### CASE

A five year old boy was brought to the hospital with a brief history of abdominal pain and vomiting. Following admission he ran a high fever, was incontinent of feces and displayed convulsions, nystagmus and irrational behavior. He died twelve hours after admission without a satisfactory diagnosis having been established. At autopsy no abnormal findings were noted until the stomach was opened and its contents were smelled. An odor of methyl salicylate was readily apparent. Chemical tests of the blood and stomach content corroborated this impression. Further investigation by the police yielded a bottle of "Muscle Aide" at the scene where the child had been playing at the time he became ill. "Muscle Aide" contains, according to the label, methyl salicylate, oleoresin capsicum and isopropyl alcohol.

Alerted by the information acquired by his eyes or nose, the pathologist can confirm his suspicions by submitting appropriate materials to the toxicologist for corroborative analysis. In these situations there is little difficulty in reaching a sound conclusion.

However, there are many poisons, rapidly fatal in small quantities, which impart no characteristic odor

to the body and which produce and leave minimal or no specific bodily changes. There may be no morphologic change whatsoever that can be attributed to the direct chemical action of the fatal agent. Into this category fall the alkaloids and the newer organic phosphorous compounds with their ability to interfere with vital enzyme reactions, especially cholinesterase function. The pathologist must keep constantly in mind the possibility of this type of poisoning in all obscure deaths where there are no significant gross or microscopic visceral changes. The barbiturates which are responsible for a large fraction of poison fatalities<sup>4</sup> produce no specific changes.<sup>3</sup>

In all such instances blood, urine, gastric content and organs are preserved in chemically clean individual containers for toxicologic study. As much blood as can be conveniently obtained and entire organs are saved after first removing whatever portions are needed for histologic examination. This permits the running of duplicate analyses and provides insurance against accidental loss or error during analysis. With potent poisons which kill in small amounts, sufficient tissue must be made available to the toxicologist so that he can work without undue hardship. Surplus material can be later discarded when the case is closed, but many a toxicologic problem has remained unsolved and many a case has been signed out without a definitive diagnosis because of the paucity of material saved for analysis.

The victim of a poison can sustain lethal damage and still survive a sufficient interval to metabolize or excrete the responsible agent. Here investigation of the circumstances preceding death is essential. Such, for example, is the situation in chlorinated hydrocarbon poisoning where death from liver necrosis and kidney damage may take place a week or ten days after exposure. Chemical analysis reveals absence of the offending agent at autopsy even though severe organic damage is readily apparent.

The modern toxicologist, utilizing such techniques as paper chromatography, infrared and ultraviolet spectrophotometry, x-ray diffraction and spectrographic analysis as well as the classic wet analytic techniques and bio-assay will frequently furnish the answer to a puzzling case where gross and microscopic organic changes and bacteriologic studies are uninformative. Where anatomic findings are non-diagnostic, toxicologic analysis must be carried out. Failure to do so may well be a crucial omission.

## DEATH BY NEURAL MECHANISMS

Coming within the purview of the forensic pathologist is a group of sudden and unexpected deaths where gross and microscopic anatomic findings, microbiologic and chemical studies are completely negative. These constitute the so-called "instantaneous physiologic deaths."<sup>5</sup> Such unexpected deaths in which autopsy does not reveal an organic lesion make up a small but important fraction of sudden deaths in healthy persons. The explanation for this category of sudden death requires that the pathologist function not only as a morbid anatomist but also as a morbid physiologist.

Death which occurs immediately after minor trauma in a healthy child, a robust young adult or a sound middle-aged adult presents an acute problem to clinician and pathologist. There is an abrupt dramatic transition from the glowing activity of life to the lasting stillness of death which requires explanation.<sup>6</sup> At autopsy only the basic changes of circulatory failure are demonstrable . . . diffuse visceral, mucosal and serosal congestion and capillary hemorrhages. These findings are nonspecific and are present in varying degree in almost all forms of death. Cessation of vital function stems from cerebral anoxia with no discernible trigger lesion.

Serious malfunction of the circulatory system can arise from mechanical stimuli which are not necessarily associated with wound production. Such functional abnormalities are neurogenic.<sup>7</sup> The pathologist and toxicologist cannot, by the methods available today, disclose the extent or nature of the responsible changes even though the changes are lethal.<sup>8</sup>

The syndrome has been termed primary shock or syncope with instantaneous exitus. It is characterized by suddenly developing circulatory failure on the basis of either reflex vagocardiac inhibition with slowing or stoppage of the heart, reflex systemic vasodilation with profound fall in blood pressure, or a combination of these two mechanisms. Instantaneous death is almost always cardiac in origin.

## INHIBITION

It has been amply demonstrated that excitation of the vagus along its course or stimulation of the peripheral end after section gives rise to bradycardia or permanent cardiac stoppage in diastole. This inhibitory action is not limited to excitation of the vagi directly but can be accomplished also via a

reflex arc.<sup>9</sup> Deaths from inhibition are defined as those sudden deaths which occur within seconds or not longer than two minutes after minor trauma or peripheral stimulation of a relatively simple and ordinarily innocuous nature. Investigation of the circumstances surrounding death discloses that peripheral irritation or stimulation has probably initiated a fatal inhibitory reflex.

## CASE

An eight year old boy was struck on the chest by a baseball which had been batted from the hand of an eleven year old boy standing about eighteen feet away. Immediately after being struck, he collapsed. Oxygen was administered by inhalator, but he did not respond and was pronounced dead fifteen minutes after the incident. Gross and microscopic autopsy studies were negative for evidence of disease, injury or congenital anomaly.

A variety of events has been incriminated as possible causative agents in death from inhibition, viz., a blow to the larynx,<sup>10</sup> a punch in the epigastrium, a kick in the scrotum, canalization of the cervix,<sup>11</sup> puncture of the pleura,<sup>12</sup> and pressure on the carotid sinus.<sup>13</sup> Impingement of cold water on the nasal and postnasal mucosa after sudden immersion in cold water has been described as a trigger mechanism for setting off the cardio-inhibitory reflex.

ANATOMIC PATHWAYS AND PHYSIOLOGIC MECHANISMS  
IN DEATH FROM INHIBITION

The mammalian heart is under the nervous control of the autonomic system with sympathetic and parasympathetic divisions acting as antagonists, augmenting and inhibiting cardiac function. Although cardiac rate is determined by the pacemaker in the sino-auricular node, natural tempo is controlled by the balance of inhibiting and accelerating impulses which reach the heart via the autonomic pathways.

Strong stimulation of both vagi leads to diminished cardiac contractions and ultimately to complete heart block with idioventricular rhythm and a slow feeble beat. Weak cardiac contractions result in inadequate coronary flow and myocardial anoxia. Asystole or ventricular fibrillation supervenes with fatal cerebral anoxia. The rate of circulatory change plays a fundamental role in the production of fatal and nonfatal syncope.

The autonomic system is constructed on the plan of a reflex arc. Any afferent fibre, somatic or visceral, may carry to the central nervous system impulses capable of mediating a response by smooth muscle, gland or heart. Psychic stimuli have the same poten-



tialities. With its generalized visceral distribution and multiple connections with the central nervous system, the autonomic system is an ideal preformed pathway for the transmission of inhibitory impulses, fatal and nonfatal, to the heart.

While some hold that cardiac syncope is always the result of asystole,<sup>5</sup> others are of the opinion that asystole is the basis of temporary cardiac syncope, and that ventricular fibrillation is the irregularity underlying fatal syncope.<sup>14</sup>

A combination of cardio-accelerator impulses plus a discharge of epinephrine acting synergistically can throw the heart into ventricular fibrillation. All effective contractions cease and death ensues. Here is another possible mechanism to explain death from inhibition.

Many patients who have died during the taking of an electrocardiogram have demonstrated ventricular fibrillation in their dying records. This arrhythmia may usually be, and perhaps always is, the last convulsive tremor of a dying heart. That trivial lesions can inaugurate the fatal rhythm is well known.

#### ETIOLOGIC FACTORS IN DEATH FROM INHIBITION

If the concept of cardiac inhibition is valid, why are deaths infrequent which can legitimately be ascribed to it? The events accused of initiating cardiac inhibition are certainly not rare. Blows to the solar plexus are received in profusion by the professional pugilist, impacts to the scrotal contents are the lot of every active male, cervical canals without number are irritated every day in gynecologists' offices, and the professional wrestler has his carotid sinuses stimulated any number of times by his opponent. Yet fatalities following any of the above stimuli are rare. Apparently inhibition normally passes off sufficiently rapidly so that functional recovery ensues before myocardial and cerebral ischemia have gone to the point of irreparable damage. There is no age or sex predominance in death from inhibition.

We cannot predict who will fall prey to this syndrome. The healthy human mechanism with its adequate emergency reserve can usually re-establish equilibrium by the interplay of homeostatic mechanisms. In some instances when the vital organs according to our present methods of examination are completely normal, return to efficient function is difficult, slow or may not occur at all. In the light of our present knowledge we must beg the question of the etiology of death from inhibition.

#### CLINICOPATHOLOGIC CORRELATION

Inasmuch as death from cardiac inhibition results from trauma so minor as to leave minimal or no evidence at autopsy ("microtrauma"), all possible information concerning the circumstances must be obtained if a solution to the case is to be reached. Observations of witnesses and bystanders may offer the only clues for an understanding of what has transpired. The pathologist must leave the laboratory and search elsewhere for his answer.

Death from inhibition must be diagnosed only by exclusion. When serious natural disease and trauma have been eliminated by a complete autopsy and when toxicologic analysis is reported as negative, then and only then may the diagnosis be seriously entertained.

#### SUDDEN AND UNEXPECTED DEATH IN INFANCY

Sudden and unexpected death at any age is a catastrophic and tragic event. In infancy it is especially so. In forensic practice sudden death in apparently well infants is a common event. Each year in Cleveland we see between 75 and 100 infants who have been found dead in their cribs with either no history of preceding illness or with a history of such mild illness that there was no reason for alarm. Such cases are a source of bewilderment and self accusation on the part of the parents. Confronted by an infant who only a short time previously appeared completely well and is now found cyanotic and dead face down in his crib, the layman immediately concludes that the child has been mechanically asphyxiated in his bedding. The coroner or medical examiner looks at such a child, notes no evidence of injury, and signs the death certificate as accidental mechanical suffocation. This is a particularly unfortunate diagnosis.

An adult found dead in bed after having gone to sleep with no signs of illness is usually felt to have died of degenerative vascular disease or intracranial hemorrhage. The death of an infant under similar circumstances is frequently felt to be accidental. Even when postmortem examination is carried out, the true state of affairs may not be brought to light. The pathologist notes that the child is well developed and well nourished and without external evidence of acute or chronic disease. There may be bloody foam in the mouth and nostrils and staining the cheeks. Internally he finds subepicardial and thymic petechiae, congested, edematous and hemorrhagic lungs, bloody froth in air passages, and that is about

all. If no microscopic studies are carried out, no organic disease is noted, and death is erroneously attributed to "smothering in bed clothes."

We have recently completed the field work in a two year survey of sudden and unexpected deaths in infancy in Cuyahoga County. The study of each case has included a complete gross and microscopic autopsy, bacterial and viral cultural studies, and a home visit by an epidemiologist who has thoroughly investigated all details of the infant's remote and recent past. By a complete autopsy I imply gross and microscopic examination of all organs including such oft neglected areas as the middle ears and mastoids, the larynx and vocal cords, the hilar areas of the lungs and several areas of the brain. By such an approach disease whose presence was completely unsuspected is frequently disclosed. While our statistics are as yet incomplete, there are a few broad generalizations which we can safely make at this time.

Sudden death in infancy is most frequently the result of an infectious process. Necrotizing laryngitis, hilar bronchitis and tracheitis, myocarditis and encephalitis are seen where gross appearances are quite normal. The importance of microscopic study cannot be too strongly emphasized.

The immunogenic defenses of the infant are not nearly as well developed as those of the adult, and the child is vulnerable to infectious agents, bacterial and viral. The bulk of our cases occur in the age range of one to five months with a peak at two to three months. This leads to the conclusion that a child is most apt to die in this abrupt fashion after passive immunity has worn off and before active immunity has been developed.

From a clinical point of view the infant is unable to vocalize complaints about pain, dyspnea or malaise. Moreover, the bodily reserves in the infant are much more limited than those of an adult. A fatal illness may develop rapidly without attracting the attention of even the most watchful parents. We have found the same organic changes in infants who died swiftly under observation following the onset of severe symptoms as in those found dead in their cribs. We have had infants brought to the coroner's office who had been examined by a competent pediatrician and found to be perfectly healthy within twelve to twenty-four hours of their being found dead.

Experience has taught us that many infants who are brought to the coroner's office with the terse

statement by the police, "This child found dead in crib. No history of illness," have in reality not been completely well. When the shock of the infant's death first strikes, the reliability of the data furnished by the emotionally traumatized parents is nil. The distraught father and mother are in no position to furnish a logical or coherent description of what has gone on. After the passage of a few days, sympathetic and careful interrogation frequently discloses that the child had presented signs of a mild illness or respiratory infection, had been fussy and generally had not been acting completely well for half a day or a day prior to his being found dead. The word "premonitory" is incorrect to characterize the signs of mild illness that are described. There is nothing that warns parent or physician of a possible lethal outcome. In retrospect, however, minor symptoms take on significance.

For the moment we have no etiologic agent that we can incriminate in these infant deaths. Bacterial studies have been noteworthy only in their inconsistency and nonspecificity. Viral culture studies of the brain, spleen, lungs, lymph nodes and tonsils carried out at the National Institute of Health by mouse and fertilized egg techniques have failed to yield anything of significance. There is much work to be done.

Time does not permit a complete description or analysis of the variety of lesions found in this group of infants. Unsuspected acyanotic varieties of congenital heart disease are seen in moderate number. Most common is endocardial fibroelastosis (idiopathic cardiac hypertrophy). Unusual and uncommon diseases are seen including vascular diseases of degenerative or inflammatory nature, whose presence again was unsuspected. Suffice it to say that any infant who is found dead under the circumstances described is deserving of a complete autopsy.

Smothering in bedclothes is an outworn obsolete thesis that should not even be mentioned unless there is frank physical evidence of strangulation. It stigmatizes the parents as being responsible for the death which is both cruel and incorrect. A healthy child cannot smother in ordinary bedclothes. From the anatomic point of view it has recently been emphasized that there are no pathognomonic changes characteristic of mechanical asphyxia save for those directly due to the asphyxiating object or mechanism.<sup>15</sup>

Status thymicolymphaticus, a phrase that exemplifies medical gobbledegook at its best (polysyllabic



and with Latin endings), has been and is still occasionally invoked as an explanation for sudden death in infants and adults. It is a meaningless expression.

Aspiration of vomitus occasionally seen in these infants and postulated as the cause of death is more likely to be an agonal phenomenon rather than a causative mechanism.

The problem of sudden and unexpected death in infancy is a large one with many avenues still to be explored. The source of the infection, its means of transmission, the mechanisms of death, the immunologic relationships of host and invasive agent and other questions remain to be answered. No child found dead in his crib should be signed out without thorough postmortem study. Complete autopsy will frequently disclose severe organic disease previously unsuspected and thus clarify, at least partially, a mystifying situation. There is a residue of cases which present no anatomic cause of death, infectious or otherwise.

#### ACKNOWLEDGMENT

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## CANCER OF THE LYMPH NODES

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#### SUMMARY

When any unexplained lymph node enlargement is

encountered, a biopsy specimen should be taken.

A brief clinical classification of Hodgkin's disease and lymphosarcoma is reviewed which is of aid in choosing the type of treatment to be employed.

Therapy of Hodgkin's disease and lymphosarcoma is discussed, with a brief review of the agents found useful, their dosage, degree of effectiveness, limitations, and principles governing their use.

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THIS discussion will stress the two aspects which I consider the most important from the practitioner's point of view, namely, the diagnosis and treatment of these disorders.

#### DIAGNOSIS

The first requisite for making any diagnosis is to have a high index of suspicion. This is certainly true for the two most common cancers of the lymph nodes, namely, Hodgkin's disease and lymphosarcoma. It is not uncommon to see a patient who has had an asymptomatic lump in the neck for a number of months but who has been told to disregard it since it has given rise to no symptoms. Because of our present concept of the pathogenesis of these diseases it is precisely at this stage, where only one node may be involved, that one should elucidate the problem. I should like to stress the importance of obtaining a biopsy of a lymph node which is enlarged when a reason for such enlargement is not apparent. As we all know, lymph nodes of the neck may enlarge because of infection in the nasopharynx or in the mouth. Some generalized diseases such as infectious mononucleosis, German measles, and some of the other exanthemata also cause lymph nodes to increase in size. When a thorough investigation fails to reveal an adequate cause for lymph node enlargement, however, a biopsy definitely is indicated if such enlargement persists for more than several weeks.

The services of a well trained pathologist are essential at this stage of the investigation. One can say without fear of contradiction that the evaluation of a lymph node biopsy is one of the most difficult in the field of pathology. Although the diagnosis is not difficult when the pathologic picture is classical, the variations which can exist are numerous and often the diagnosis is most difficult indeed.

If a patient presents himself with lymphadenopathy in several regions of the body a cervical or axillary node should be chosen for biopsy. It is very common to see the inguinal nodes distorted in their microscopic appearance, presumably due to repeated infections in the areas which they drain. It should be stressed that before any treatment is begun a biopsy must be obtained, for this method represents the only means for certain diagnosis when a thorough examination and routine laboratory work-up have failed to give evidence that the lymph node enlargement is secondary to some underlying disease.

In discussion of the treatment of Hodgkin's disease and lymphosarcoma I should like to refer to the

classification suggested initially by Craver<sup>1</sup> and elaborated by Diamond<sup>2</sup> for it has clinical usefulness in choosing the treatment if it is applied at the time the patient is first seen and diagnosed.

Class I—Disease limited clinically to a single locus (unifocal unicentric origin); no constitutional symptoms or signs (i.e., fever, night sweats, pruritis, weight loss, anemia or fatigue).

Class II—Disease limited regionally (regional anatomic distribution, i.e., all apparent disease above the diaphragm, or all apparent disease below the diaphragm) with or without constitutional symptoms and signs.

Class III—Generalized (universal) disease with constitutional symptoms and signs.

I think that the principles of therapy may be best discussed by referring to this classification. When a patient is first seen whose disease is limited to a single area and who has no constitutional symptoms or signs, in other words belongs to Class I, aggressive treatment with x-irradiation is indicated. At this stage of the disease it is at least theoretically possible that this patient may be cured. It is for this precise reason that early diagnosis is considered to be so very important. In certain selected cases of this group surgical removal of the affected nodes en bloc followed by x-ray therapy may be indicated. The usual x-ray therapy given to these patients utilizes high voltage (250 Kv) to a total air dose of approximately 3000 r over adequate portals in divided doses given over a two to three week period. The principle of "cross fire" is utilized to spare the skin while rendering maximal treatment to the affected nodes.

Those patients who when first seen fall into Class II, where the disease is limited regionally but who have no constitutional symptoms are probably best treated by x-ray therapy. In these patients the so-called "obliterative" doses are not used but rather a less intensive x-ray course is given. To generalize, one may say that usually 2,000 to 2,500 r are delivered to adequate portals usually over a period of two to four weeks.

In the Class II patient who presents himself with constitutional symptoms it may be helpful to give a course of nitrogen mustard which then may be followed by a course of x-ray therapy. It must be stressed that the course of x-ray therapy should not be given during that period when the toxic depressive effects of the nitrogen mustard are present. As will be discussed later, the depressive action of nitrogen



mustard on the bone marrow may last for three weeks. If x-ray therapy is administered during that period of time it is possible to produce a peripheral leukopenia of abysmal proportions and to depress the bone marrow irreversibly with ensuing demise.

The principle to be remembered in treating the patient in Class III is that the distress caused by the treatment should never be greater than that which occurs from the disease itself. In other words, one's chief concern should be the overall comfort of the patient. In these patients nitrogen mustard either in the form of  $\text{HN}_2$  (methyl-bis-beta-chloroethyl amine) or TFM (triethylene melamine) is the therapy of choice because of the effect of these drugs on the constitutional symptoms. X-ray therapy may then be directed to tumor masses which may exert pressure on vital organs. Again the additive toxic reaction of these various therapeutic agents must be recognized in order to avoid the complications mentioned a short while ago.

#### TREATMENT

I will now discuss the principles involved in the use of the various therapeutic agents which we have just mentioned. X-rays represent the preferred method of administering irradiation for in these diseases they are superior to either radioactive phosphorus or radium. X-ray therapy may be directed either locally to restricted portals outlined over the areas of involvement, or may be administered as total body irradiation in occasional circumstances. X-ray therapy is essential when the following sites are affected by Hodgkin's disease or lymphosarcoma: 1, the nasopharynx or the base of the tongue or tonsillar region where obstruction of the airway is an imminent danger; 2, genitourinary tract obstruction where lymph node pressure blocks the excretory channels; 3, spinal cord lesions where pressure by extension of the disease gives rise to the ominous signs of paraplegia. In spinal cord lesions where there is danger that application of x-ray therapy may induce edema with increase in symptoms and signs, a course of intravenous nitrogen mustard is first administered then highly localized x-ray therapy at the proper level may be administered shortly thereafter.

When x-ray therapy is administered locally the most common toxic effects are skin irritation and occasionally anorexia, nausea or vomiting. As has been mentioned above, the principle of "cross fire" is utilized whereby an underlying tumor mass is

irradiated through different areas of skin. When the therapy is directed over bone marrow sites a leukopenia may result and must be watched for. This result is much more common when total body irradiation is employed. It must be remembered that the blood count may not fall for ten days to two weeks after initiation of the x-ray therapy.

The beneficial effects of irradiation include the disappearance of the lymph node enlargement, relief of pressure symptoms, and disappearance of fever and pruritis in occasional instances. Where anemia is present it is common to see this disappear after appropriate x-ray therapy. There is no question that x-ray therapy is the treatment of choice where constitutional symptoms do not exist.

The action of nitrogen mustard ( $\text{HN}_2$ ) simulates that of irradiation<sup>3</sup> but has a greater effect on constitutional symptoms. It has a greater effect on rapidly proliferating cells and thus affects abnormal tissue more than normal tissue. In many instances its effect is most dramatic. Fever may resolve abruptly and pruritis disappear. The beneficial effect of a course of nitrogen mustard may last anywhere from a few weeks to several months, but the subsequent response generally becomes shorter with each ensuing course.

The dosage of  $\text{HN}_2$  usually employed is 0.1 mg. per kg. of body weight administered intravenously daily for four days. The drug is obtained as a dry powder which is diluted in saline to a concentration of 1.0 mg. in 1 cc. of solution. Because of its highly irritating properties it is mandatory that the material be directly introduced into a vein without contamination of the overlying tissues. In order to achieve this most surely an infusion of saline is started, then the calculated dose of nitrogen mustard is administered directly into the lumen of the infusion tubing. It should be stressed that because of the rapid disintegration of this drug in solution the time between the solution of the dried powder and its administration to the patient should not be greater than five minutes.

The immediate toxic effect of nitrogen mustard is the appearance of nausea and vomiting in at least 80 per cent of the patients. This is a distressing but not usually dangerous effect, except in those occasional patients whose platelets are greatly diminished and in whom fatal bleeding can occur upon rupture of a vessel induced by violent retching. The most important toxic effect of nitrogen mustard, however,

is the production of leukopenia and thrombocytopenia which may appear in from two to twenty-one days. In an attempt to avoid serious toxic depression of either the platelets or white cells it is common practice to do a daily blood count during the course of therapy and to withhold subsequent doses if much of a change in either white cells or platelets occurs. When a complete course has been administered the patient should be followed carefully for at least three weeks to determine the depth of the leucocyte depression. This is especially important if a subsequent course of x-ray therapy is contemplated. The course of nitrogen mustard should not be repeated until it is evident that the bone marrow has recovered from the initial insult. It should be remarked that Hodgkin's disease is more often favorably affected by nitrogen mustard than is lymphosarcoma.

Triethylene melamine (TEM) is a nitrogen mustard-like compound which acts on tissue in a manner similar to  $\text{HN}_2$ . Its advantage is that it may be given orally and that it does not cause nausea and vomiting as frequently as does  $\text{HN}_2$ . The dosage is usually 2.5 mg. ( $\frac{1}{2}$  tablet) administered daily for four days. Because of its very unpredictable depressant effect on the bone marrow it is common to space the doses with two or three days intervening. A constant check on the hematologic status of the patient is necessary and even despite these precautions a profound depressing effect may result. Leukopenia usually occurs between the seventh and fourteenth days after the first dose. Not more than 10 mg. should be given over a period of one week. Another complication of triethylene melamine therapy may occur in some patients with lymphosarcoma in whom a rapid destruction of cells occurs. Hyperuricemia may develop<sup>4</sup> and uric acid crystals may obstruct the kidney tubules or ureters to cause uremia. If this occurs alkalinization of the urine should be instituted and the patient have the ureters washed out by retrograde catheterization if necessary. Triethylene melamine is very definitely more difficult to administer than is  $\text{HN}_2$  because of its unpredictability from patient to patient. For this reason I believe its use by anyone except those acquainted with its

vagaries is hazardous, for even those who use it commonly can get into trouble.

Cortisone and ACTH may be useful in patients with disseminated Hodgkin's disease who may show a temporary decrease in the size of the lymph nodes, liver or spleen. A more constant result, however, is merely the generalized beneficial effect that may be seen upon administration of these agents for any disease. However, in patients with an associated acquired hemolytic anemia ACTH or cortisone may control this aspect of their disease.

Although it is probable that the prognosis in these diseases depends essentially upon the inherent nature of the process, it must be admitted that with these newer chemotherapeutic agents at our disposal and with our now greater experience in the application of x-irradiation, the patient's life may be made more comfortable if not actually prolonged. Because of the wide variation in the natural course of the disease it is impossible to state that any therapeutic regime can be said actually to prolong life, however, some very impressive results have been reported in terms of five and ten year survival rates when x-ray therapy is applied early and vigorously in the course of the disease.<sup>5</sup> The nitrogen mustard compounds definitely enable one to help a patient who formerly was beyond help when x-ray therapy alone was available. Continuing efforts are being expended in the direction of investigation of new compounds which may be found to have even more effective toxic action on the abnormal cells involved in these diseases but which will not be too toxic for normal tissue.

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## THE DARWIN THEORY

### Its Present Antibiotic Implications

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Who would have dreamed in 1859 that the Darwin doctrine would have its repercussions in the kind of thinking involved in the explanation of microbic behavior patterns developed as a result of antibiotic therapy today? Yet in the study of the evolution of resistant microbic strains we become involved immediately in the doctrine of evolution which has completely changed the natural philosophy of our times.

The deep effect has lasted from about 100 years ago to the present day, influencing new approaches to almost every field of intellectual endeavor and remaining the center of the biological sciences and also responsible for progressive thought in other sources.

The formed products of the history of life fade into the background when the study of organic evolution is approached. In their place we become concerned about the elementary units, the genes, which it is believed are responsible for the miraculous organic developments (large or small—visible or invisible, to the naked eye) in this universe.

The hereditary basis involved in material evolution resides in the germ plasm. The genetic material is largely contained in the chromosomes (whose size is at the molecular level), possessing only properties of chemical compounds.

The basic fact about genes is that each one of them is derived from another gene by reproduction. The latter process, however, does not parallel reproduction in the same sense that "a complex whole organism delegates the power to a part of itself to continue the existence of the species."<sup>1</sup>

A parallelism in this latter basic process of reproduction of molecular entities exists in the propagation pattern of microbes. No striking chemical difference has as yet been detected between virus particles, capable of reproduction and inert particles, from normal tissues. Nor has it been possible to

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#### SUMMARY

The basic concepts of the Darwin theory have been reviewed briefly with reference to contemporary problems inherent in antibiotic therapy.

The therapeutic difficulties and the physician-patient relationship thereto have been pointed up. Reference has been made to the importance of progress now being made in fundamental microbiological research, which it is hoped will answer the many questions raised by men of science the world over, struggling with the solution of control of resistance in the evolution of new microbic strains. The imponderables are seemingly more apparent than real.

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associate the property of life with any chemical or group of chemicals.

The continuity of the germ plasm depends upon the continuity of genes, whose genetic reproduction depends upon biochemical processes whereby a gene molecule gathers molecular parts from its cellular environment, and by natural affinity recreates a nucleoprotein complex, which is a reproduction of itself. By this process it is believed that continuity of the germ plasm is established.

Amongst viruses and microbes variation does occur in continued passage, with alterations in trait, which differ from the original stock. The factors initiating the variation are unknown, but may be related to environmental adaptation, which depends on induced qualitative change in the original stock.<sup>2</sup>

As an example of a variant we can cite the 17 D strain of yellow fever developed by passage through tissue cultures. It gives rise to immunity to yellow fever in its attenuated form and is devoid of all tendency to produce yellow fever in man.

The problem of the reaction of microbes, rickettsiae, and viruses to chemotherapeutic drugs and antibiotics is of great interest.

It was found soon after the introduction of antibiotics for therapeutic purposes that they did not always fulfill cure expectation, because some bacteria had apparently acquired resistance.

While a number of physicians believe that ultimately all bacteria will acquire resistance and that antibiotics as a class will eventually lose their usefulness, there are others in the world of science who are more optimistic about acquired resistance, because it has made it possible to study evolution in the light of Darwin's doctrine.

The question may be asked: How do bacteria acquire resistance to antibiotics? The answer is through hereditary variation, mutation and selection, as an adaptation to their new found environment, resulting in an array of hereditarily different forms (ecotypes) whose number depends upon the rate of mutation. There are to be sure degrees of adaptiveness of these "mutants" as measured by reproductive survival in new ecological niches. Neo-Darwinism, or the genetic theory of the means of evolution, bases itself upon the existence of random mutations (a theoretical possibility), which seems to apply where emergence of resistance becomes apparent.

Evolution requires continuity plus change; ever recurring revolutionary processes which we recognize and label as mutations, which represent a sudden change in the framework of the chromosomes within the nucleus of a cell.

Evidence indicates that changes in bacteria from sensitivity to resistance originate as mutations upon which antibiotics act only as selective agents. These eliminate the sensitive bacteria, allowing the resistant mutants to thrive and multiply unopposed. These changes in bacteria also occur because a certain per cent exist in a form different from that in which observations are usually made.

Another reason may be that in vivo a large number of organisms, as for example in tuberculosis, may be locked within phagocytic cells, instead of being free in body fluids where the bacteria are readily reached by antibiotics. The idea of the existence of "drug inhibitors" in areas where cellular debris walls off bacteria by creating a physicochemical environment favorable to bacterial defense and survival is worthy of mention.

The phenomenon of dormancy or potential viability

in what may be regarded as "dead" bacilli, which though apparently dead, possess revival attributes under changed environmental conditions favorable to their revitalization, is not new in the microbiological world.<sup>3</sup>

We may question whether or not these resistant mutants indicate a degree of adaptiveness, as measured by reproductive survival values, that provide new genetic combinations, suitable for survival under new stresses and strains imposed upon them in a new ecology and a new mode of life.

The development of resistance follows a definite pattern, with resistance attained in successive steps, but not necessarily equal, with the mutated gene always reproducing its kind with the resultant new hereditary type.

Resistance patterns have been shown to differ with different antibiotics. Genetic bacterial influences may be operating in these behavior patterns. If any one of the genes should mutate, the bacterium in which such mutation occurs and the resultant strain developed therefrom is an array of hereditarily different forms which by chance will be more resistant to respective antibiotics than was the original "first step resistant strain."<sup>4</sup>

Whether such divergence from the accepted norm will prove eventually to be disadvantageous to man by the development of a new threat to his survival remains to be seen. Newer chemotherapeutic agents and antibiotics may keep pace with the development of microbial mutants, which now appear to threaten man's existence.

Or on the other hand, the host man may by evolutionary necessity adapt himself and gain protection through an elaboration of increased immunal response against a new world of infectious organisms, for his successful escape from annihilation.

This process would seem to put at rest the concern of some physicians who believe that ultimately all bacteria will acquire resistance and that antibiotics as a class will cease to be useful.

What then are the therapeutic implications?

Opinions held at present, either for or against the value of antibiotics as standardized routine in preventive medicine, may require modification in the light of further evidence developed by experience with their pharmacodynamics in man. Passing enthusiasms will wax and wane. To date, the advantages would seem to outweigh the disadvantages in their use in the sphere of preventive and curative medicine.



Certain technical problems must be dealt with. Precise determination of the type of infection should whenever possible be the guide in the choice of proper antibiotic therapy. Indiscriminate reliance upon an antibiotic rather than upon the antibiotic of choice coupled with premature, hasty and unconfirmed diagnoses can mar the real diagnosis and actually retard recovery by distorting clinical manifestations of disease.

Those who are called in consultation for confirmation of a communicable disease diagnosis run into the difficulties imposed upon them by conditions mentioned, yet from no fault of the physician in attendance. Many times he is torn between limitations of technical or monetary aid in arriving at a careful diagnosis and the pressure exerted by parents, who insist upon the use of the "wonder drugs" regardless of the doctor's admonitions that the fundamental cause of disease should first be determined and that care must be exercised in avoiding known adverse effects.

On the other hand, the overwhelming number of antibiotics now made available to the physician compound his problem of proper selection. He can resort to the broad spectrum antibiotics that affect gram-positive and gram-negative bacteria, as well as the rickettsial and some of the larger viruses. The clinical behavior pattern of the more frequently used antibiotics has been reviewed and the advantages and disadvantages of their use singly or in combination pointed up.<sup>5</sup> The best results are still obtained in the majority of cases with the most active single antibiotics, with demonstrated biological efficacy, for the properly chosen case, as based upon prior evaluations.

Meanwhile, we must depend upon a crystallization of opinions based upon studies by members of the medical profession and the ancillary biological and chemical sciences, to indicate the optimum types of therapy for the control of infectious and communicable diseases, upon which much attention has been focused in the field of preventive medicine.

Nothing should prevent men delving in the spheres of pure science from continuing their tireless search

for better and more potent therapeutic agents.

The elementary events running through evolutionary substrata may yet open vistas into the methods of the world's existence and future being, which cannot but make salutary impressions upon all faculties of the human mind. So let us take heart and hope that man will continue to exist (unless overwhelmed by violent conquests of the atomic age) and will discover ways and means to counter those elements in his ecology forever threatening his existence. Lack of objectivity of bigoted fundamentalists or science by communistic decree should not be permitted to stand in the way of scientific progress. "It is because science is sure of nothing that it is always advancing." (Duclaux).

The center of biological thought formulated some 100 years ago by Charles Darwin in 1859 remains a pivotal idea, shedding light on all the different phases of the work of microbiologists, who measure the meaning of their work by the yardstick of his brilliant generalizations. No theory has ever made the same impact upon the minds of men in all walks of life and upon almost every field of intellectual endeavor, particularly in the field of biological science and research.

More observations, more experiments, more measuring, checking, analyzing, evaluating and confirming must continue. "Science in obeying the law of humanity, will always labor to enlarge the frontiers of life." (Pasteur).

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## BORIC ACID POISONING

## Report of a Case and Survey of Connecticut Hospitals

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## SUMMARY

The case of a four week old boy with transcutaneous boric acid poisoning is reported. This and five previously unreported cases uncovered by a Connecticut hospital survey are added to 114 cases from the literature. It is apparent that boric acid is a dangerous and therapeutically inefficacious drug.

BORIC acid poisoning by the oral route is a familiar hazard.<sup>1,2</sup> The New London tragedy is well remembered by Connecticut practitioners.<sup>3,4</sup> On the other hand, transcutaneous poisoning is not often encountered or not often recognized (Table No. 1). The danger of the topical application of boric acid has been the subject of a number of recent articles<sup>5-11</sup> and prompted this report of a case with a favorable outcome on symptomatic therapy.

## CASE REPORT

R. M., a four week old white male, was admitted to the Hospital of St. Raphael on October 29, 1953. The present illness had begun at two weeks of age with lengthening periods of crying, especially toward evening. Soon after a redness of the buttocks was noticed. The feeding of orange juice was discontinued. Corn starch and mineral oil were applied to the diaper area instead of the previously used borated baby powder. When the infant was three weeks old the family physician was contacted and he advised dusting the diapers with boric acid powder. The irritability continued and the erythema spread to the abdomen and thighs. On the fourth day of boric acid application the face became erythematous. At this time the boric acid was stopped and Desitin Ointment was started. Benadryl was prescribed and pabulum was added to the diet. On the following day the temperature rose to 101° F. and the face became fiery red. Desquamation and nonprojectile vomiting of almost all feedings occurred during the next 24 hours. The stools became loose, green, and contained mucus but never blood. The pabulum, vitamins and formula were stopped and the baby was offered a hypertonic salt and sugar solution. The vomiting, diarrhea, extreme irritability, and sleeplessness progressed. On the day of admission the vomitus was found to contain streaks of bright red blood.

The past history revealed that the infant weighed seven pounds four ounces at birth. The immediate postnatal course was uneventful. A circumcision performed on the fifth day of life healed without difficulty. The feedings consisted of diluted evaporated milk with added Karo. A multivitamin preparation and orange juice were started on the eighth day.

The family history is of interest in that the mother

develops a weeping eczema of the ears on contact with metal jewelry.

## PHYSICAL EXAMINATION

Physical examination revealed a desperately ill but well nourished white male infant apparently out of contact with the environment. The temperature was 99.2° F., pulse rate 180, respiratory rate 63. The weight was ten pounds two ounces. The body measurements were within normal limits. There was a generalized desquamation which was most noticeable over the head, midabdomen, buttocks, groin and thighs. Underlying the scales the skin was of fair turgor, shiny, very erythematous and fissured. There was no lymphadenopathy. The head was symmetric, the neck supple, the anterior fontanelle two by two centimeters and flat. The eyes were fixed in an upward gaze; the pupils were four millimeters in diameter and reacted to light. The sclerae and conjunctivae were clear and funduscopic examination was normal. There was no nystagmus. The nose and throat were not remarkable. The chest was normal except for rapid shallow respirations. The lungs were clear to percussion and auscultation. The heart rate was rapid but the sounds were of good quality and there were no murmurs. The heart was not enlarged. The abdomen was tightly distended and tympanitic except from the umbilicus to the pubis in the midline. Here a firm mass was found which disappeared after the infant was stimulated to void. Neither the liver nor spleen were palpable. The bowel sounds were virtually absent. The genitalia were normal. The hands were clenched and the extremities, which were tightly flexed, twitched intermittently. Their waxen mottled appearance and poor venous return suggested shock. The deep tendon reflexes were active and the Moro sign exaggerated. The Chvostek and Trousseau signs were absent.



TABLE 1

Survey of 33 hospitals covering 3-15 years

Cases where the amount of boric acid was obviously inadequate to cause poisoning have not been included

CONNECTICUT HOSPITAL SURVEY						
HOSPITAL	AGE	NUMBER		OUTCOME		COMMENTS
		INGESTION	PERCUTANEOUS	RECOVERED	FATAL	
Hartford	1 week	1		1		4 tablespoons Boric Acid used in place of Dextrimaltose in the preparation of formula. Given 2 ounces most of which was vomited. Gastric lavage performed. Recovered uneventfully. Estimated ingestion: 4 Gm.
Lawrence and Memorial <sup>3</sup>	Newborns	20		15	5	Boric Acid used in place of dextrose in preparation of feedings. Estimated ingestion: 10-13 Gm.
New Britain General	4 months	1		1		Infant fed 45 cc. saturated solution Boric Acid instead of sugar water. Was caused to vomit and gastric lavage performed. Findings were a papular eruption on the chest, fever, increased capillary fragility and mild anemia. Recovered promptly on Vit. K. Estimated ingestion: 2½ Gm.
Norwalk	2½ years	1		1		Ate ¼ lb. Boric Acid Powder. Admitted in coma and shock. Petechiae were present on upper chest and reflexes were sluggish. Pupils contracted. Gastric lavage performed and Boric Acid found in stomach contents and 4 daily urines. Recovered quickly with liberal fluids without developing further symptoms.
	1½ years	1		1		Unstated amount of Boric Acid ingested. Infant developed albuminuria and an erythematous rash which desquamated. Recovered with liberal fluids.
St. Francis	5 years		1		1	Burns treated with Boric Acid Ointment. Child expired and at postmortem, cause of death was found to be Boric Acid Poisoning.
St. Raphael	4 weeks		1	1		Case reported here.
Totals		24	2	20	6	

The admission diagnosis was transcutaneous boric acid intoxication.

#### LABORATORY EXAMINATIONS

Laboratory examinations on admission revealed a hemoglobin of 10 Gm. per 100 cc. with a red cell count of 2,870,000, and a white cell count of 7,350 with a slight left shift. The nonprotein nitrogen was normal. The serum chloride concentration was 94.2 mEq per liter; the carbon dioxide content was 25.1 mEq per liter. Urinalysis was negative. The nasopharyngeal culture revealed the usual flora and beta-hemolytic streptococci (throat only). The blood culture grew out hemolytic staphylococcus aureus but this was felt to be a contaminant. A repeat complete blood count three days later showed no essential change. Urine collected on November 3, eight days after the last known exposure of boric acid, was subjected to spectro-

graphic analysis by the toxicology laboratory of the Connecticut State Department of Health, and was found to contain boric acid.

#### HOSPITAL COURSE

On admission the infant was placed in oxygen. The skin was cleansed with sterile saline. Sodium luminal 15 mg. was administered every eight hours. Aqueous procaine penicillin 300,000 units daily was given. Calcium gluconate 10 cc. of a 10 per cent solution given intravenously did not seem to influence the rigidity or seizures. Parenteral fluid therapy was calculated to combat shock, replace deficits, and provide liberal maintenance fluids to obtain a good urinary output. This is outlined in Table 2. The infant's condition remained critical through the first day with continuous seizures, extreme spasticity, and intermittent urinary retention.

TABLE NO. 2  
 PARENTAL FLUID THERAPY

FLUID	CC./KG	TIME (HOURS)	SITE	ELECTROLYTE (MEQ./KG.)					COMMENT
				NA	K	CL	HCO <sub>3</sub>	LACTATE	
Whole blood—50 cc.	11	0-2	I.V.	—	—	—	—	—	Combat shock and anemia
Interstitial salt solution—100 cc.	22	0.2	S.C.	3.4	0.1	2.7	0.7	—	Expand blood volume, deficit repair
K Lactate—100 cc. 5 per cent glucose in water—300 cc.	87	2-18	I.V.	2.6	0.8	2.1	—	1.1	Repair and maintenance
Isotonic NaCl—140 cc. 5 per cent glucose in water—560 cc.	152	18-36	I.V.	4.6	—	4.6	—	—	Potassium free liberal maintenance substituted for above because of urinary retention
Totals	271	36		10.6	0.9	9.4	0.6	1.1	

Thirty-six hours after admission the infant was improved. He was in contact, followed moving objects, and had no further seizures. The extremities were relaxed. The abdominal and bladder distention had disappeared and peristalsis was normal. The skin was less severely erythematous. An oral electrolyte mixture was retained and followed by a dilute Nutramigen formula which was gradually increased over the next forty-eight hours when an evaporated milk formula was substituted. No diarrhea was encountered during the hospital stay. The entire course was afebrile. Penicillin was discontinued on the fourth day. The phenobarbital was gradually decreased being discontinued on discharge. Discharge examination after six days of hospitalization was negative except for scaling of the scalp.

The scaling of the scalp persisted and cleared only after the infant was placed on Mull-Soy. It reappeared on two occasions when he was fed orange juice. He was placed on whole milk at three and one-half months of age and has been well since. Follow-up examination at six and one-half months was within normal limits.

COMMENT

The syndrome of boric acid poisoning consists of gastrointestinal, skin and central nervous system signs and symptoms. Most of these are demonstrated in the patient reported. Vomiting and diarrhea are common; the vomitus and stools frequently containing blood. The skin lesions consist of a maculopapular eruption progressing to an intense erythema usually involving the mucous membranes and sometimes most noticeable on the palms, soles and in the diaper area. This is followed in a day or two by widespread desquamation. Stupor, delirium, convulsions and coma may be encountered. In severe cases shock develops. Fever or a subnormal temperature may be present. All of the above manifestations are seen

with equal severity regardless of the route of intoxication.

Laboratory examinations have not proved of help in making the diagnosis except for the detection of boric acid in body fluids. This can be done easily with turmeric test paper or as in the case reported using the spectrographic method.

Undoubtedly some cases of boric acid poisoning go unrecognized. The picture can be confused with gastroenteritis, sepsis, meningitis, and the exfoliative dermatoses, Ritter's and Leiner's diseases. This is stressed by the fact that the last case of Leiner's disease diagnosed at the Hospital of St. Raphael, on review, revealed that large amounts of a borated baby powder and saturated boric acid solution had been used topically. In retrospect, this patient who recovered on an anallergic regimen and symptomatic therapy could have represented boric acid poisoning.

It is again emphasized that there is no specific treatment for boric acid poisoning. Liberal fluids and blood are given to combat shock and hasten excretion of the boric acid. Antibiotics, sedatives when convulsions are present and other supportive measures are indicated. Calcium gluconate has not been found effective in controlling the convulsions and there is no laboratory evidence to expect that it would do so.<sup>7,11</sup>

The mortality in 120 cases, including those reviewed by Goldbloom and Goldbloom,<sup>9</sup> several others from the literature,<sup>7,11,15</sup> the new cases uncovered by the Connecticut hospital survey and the



case reported above, is 52.5 per cent.

There is no doubt that boric acid is poisonous and that poisoning can occur by the oral, parenteral and percutaneous routes. As little as 1-2 Gm. may be fatal in a newborn infant.<sup>2</sup> Boric acid is probably not able to traverse the normal skin.<sup>9,12</sup> However, even 5 per cent boric acid as is present in some baby powders, when applied to widely denuded skin is dangerous.<sup>9,16</sup> In spite of a Food and Drug Administration report (January 30, 1954) that it had found 5 per cent boric acid in baby powders to be safe, some manufacturers have wisely removed boric acid from their product.

In view of its poisonous properties and generally accepted lack of bacteriocidal and bacteriostatic activity,<sup>13,14</sup> the use of boric acid should be abandoned in favor safer, more effective agents.

The author is grateful to Dr. Alan A. Rozen whose case is reported here; to Dr. Daniel C. Darrow whose consultation guided the management of the patient; to Drs. Willis Thayer and Thomas Murphy whose cases are included in the Connecticut hospital survey; to Mrs. Margaret Reeves, R.R.L., Miss Marjorie Smith and the Record Librarians throughout Connecticut for their valuable assistance in the gathering of data and the preparation of this paper.

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## STREPTOKINASE-STREPTODORNASE

## Its Use in the Management of Gangrene and Osteomyelitis of the Toes and Feet

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## INTRODUCTION

The management of gangrene and osteomyelitis of the lower extremity has been a very difficult, trying, and frequently disappointing experience. These unhappy patients often require high amputation after the failure of long and expensive attempts at more conservative therapy. Our study using Streptokinase-Streptodornase is based on the methods outlined in a recent report by McCarty and Tillett.<sup>1</sup> Since the results have given cause for so much greater optimism in facing these problems, we feel the method should bear re-emphasis.

## STREPTOKINASE-STREPTODORNASE

Streptokinase and Streptodornase are enzymes produced by the hemolytic streptococci. They are supplied in purified form by The Lederle Laboratories as Varidase. Streptokinase functions by changing plasminogen, present in human serum, to the active enzyme plasmin. The plasmin is then capable of catalyzing fibrinolysis. Streptodornase, the other component of Varidase, causes liquefaction of purulent material. This is accomplished by the breakdown of desoxyribonucleoprotein which is responsible for the viscosity of pus. The studies of Sherry have shown that streptodornase is actually a group of enzymes causing the breakup of these complicated molecules in separate steps. This action is direct and does not require the presence of a factor in serum.

## METHOD

The patients were brought to operation as soon as possible. All necrotic tissue, including devitalized bone, was thoroughly excised, while all viable tissue was conserved. Small bore polyethylene tubes with multiple openings were placed through the affected areas and brought out of the wound at its extremities or through uninvolved tissue. The wounds were

## SUMMARY

The presence of osteomyelitis in the feet has often meant the failure of even intensive, conservative therapy.

In our hands, surgical and enzymatic debridement has given good results and has shortened the length of hospitalization.

The method is explained and illustrated.

Three cases are presented.

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loosely approximated with interrupted silk sutures. 500 mg. of Aureomycin were added to the solution of Streptokinase-Streptodornase, as suggested by McCarty and Tillett. The total volume varied up to 50 cc. depending on the area to be treated. This freshly prepared solution was instilled in the tubes at regular intervals. The tubes were then clamped and later opened for drainage and aspiration of the liquefied products of enzyme activity. The tubes were removed after four to five days. A large surgical glove was then used as a rubber dam over areas requiring further therapy. The solution was injected and aspirated from this closed space twice daily. The dam was removed early each morning to expose the foot and provide a period of gravity drainage. Meticulous surgical debridement was carried on before each new dressing.

## CASE REPORTS

These patients presented advanced, severe infections of the feet with osteomyelitic changes. They were all diabetics. General supportive measures, antibiotics and control of diabetes were instituted immediately.

## CASE 1

C. E., a 70 year old white female, had been a known diabetic for 10 years. In November of 1952 she was seen



with infection of the first and second toes of the right foot and an adjacent draining plantar ulcer. The condition improved after incision and drainage but never completely healed. In January there was x-ray evidence of osteomyelitis in the digits and the third metatarsal. On January 12 excision of the necrotic areas was performed and the streptokinase-streptodornase therapy instituted. By February 13 the osteomyelitic metatarsal had recalcified and the foot presented a healthy granulating surface where pinch grafts readily took. To this date the foot has remained well with the patient fully ambulatory.



FIGURE 1

Case 2—X-rays pre- and postoperative



FIGURE 2

Case 2—Infected foot preoperative

#### CASE 2

S. S., a 44 year old white male, had been a severe diabetic for 10 years. In November 1952 he had an open infected lesion of the right foot and an abrasion of the left foot caused by tight shoes. With antibiotics, soaks and debridement, these lesions were controlled. However, there was x-ray evidence of an early osteomyelitis of the right third metarso-phalangeal joint. The patient was readmitted in February, 1953 because of a fulminating infection of his left foot with extensive osteomyelitis. (Figures 1 and 2.) The surgical procedure and preparation for enzymatic therapy is shown in Figures 3 and 4. Figure 5 shows the status three days later. The foot was well healed by March 9 when the



FIGURE 3

Case 2—Surgical debridement completed



FIGURE 4

Case 2—Polyethylene tubes placed



FIGURE 5

Case 2—Three days postoperative

patient was discharged. During this admission the right foot had shown a slight progression of the osteomyelitis and never completely healed. Up to this time the treated foot had remained well; although the right foot has subsequently flared up and the patient is now readmitted for the enzyme therapy of that lesion.



## CASE 3

P. R., a 53 year old white male, has been a severe diabetic for more than 20 years. He is a very difficult and uncooperative patient who does not control his diabetes well. A previous infection of the left foot in 1950 which was intensively treated, had, nevertheless, progressed to extensive osteomyelitis of the tarsal bones requiring below-the-knee amputation. Progressive infection of the right foot then occurred with loss of the third and fourth toes. In May of 1953 he presented a severe infection with osteomyelitis so that high amputation was again feared necessary. The enzymatic method, however, resulted in successful conservative management with complete healing and the patient is again ambulatory on his right foot and a left prosthesis.

## DISCUSSION

Reactions observed to Streptokinase-Streptodornase in these cases consisted of a moderate burning

sensation locally in one patient.

Successful therapy with this method requires prolonged contact between the enzymes and involved tissues. Each case presents mechanical problems that must be solved to achieve that end. The products of the enzyme action and unaffected necrotic material must then be faithfully and completely debrided.

We have observed the rapid growth of granulation tissue even over exposed bone. The question of a specific stimulation of this tissue by streptokinase-streptodornase remains for further study.<sup>1</sup>

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## CONNECTICUT'S INTEREST IN THE PROBLEMS OF THE AGING

EDWARD N. ALLEN, *Hartford*

I HAVE been asked to speak on the subject of Connecticut's interest in the problems of the aging and to say a word or two about what has already been done in this area and what is projected for the future. This is a wide subject, and I shall touch only on the high spots in discussing it. The problems of the aging have been with us from our beginning. But in recent years, through the advances in medical knowledge leading to the prolongation of life, the problem has come much more forcibly to the fore. Assisting the aged is an ancient privilege and obligation which, in our century and even in the last decade, has taken on some new, interesting, and challenging aspects. Let me confine myself, then, to some of the most recent developments in our State.

At Governor Lodge's request, the General Assembly at its last session passed an act creating a Connecticut Commission to Study the Potentials of the Aging. The Governor appointed to this Commission twelve excellently qualified members. Studies of the problems of the aging have been made in other states,

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The Author. *Lieutenant Governor of Connecticut*

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## SUMMARY

The origin of the Connecticut Commission to Study the Potentials of the Aging and its directive from Governor Lodge are stated. Some of the details of the three surveys made in Meriden are furnished. The problem of the increase in the number of aged persons in Connecticut is discussed with a view to the future.

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but in the Governor's opinion the approach elsewhere had not been sufficiently positive. What we need in Connecticut are constructive proposals for the full utilization of the skills and experience of older persons.

The directive which Governor Lodge sent to the Commission called for a detailed survey of the potentials of the older population in a particular Connecticut community. He asked the group to



address itself especially to what can be done on the positive side, and to take into account methods for the further utilization of the skills and experience of older persons in the labor force. It was and is the Governor's belief that Connecticut can find a positive solution, a solution which may, in turn, provide a pattern for other regions.

Meriden was chosen as a representative city and the University of Connecticut was authorized to conduct a survey. This research is already well under way; in fact, the field work has been completed; the data have been tabulated.

"The function of the commission," the Governor wrote, "would be one of general policy making which would involve the planning and formulation of the research and in the drafting of the recommendations. The report would be due on or before July 1, 1954.

"The responsibility of our aging population rests on many shoulders," he said. "The Commission's report would properly contain recommendations addressed to the General Assembly and useful to the administrative departments of our State Government, to the leaders of industry and labor, to our communities, and to any other group in the State whose participation is required in the solution of the problem."

Actually, three surveys were made in Meriden by the Governor's Commission. The first dealt with persons who were 55 to 64 years of age, the group that are approaching retirement age. An account of their skills and job experience was obtained. They were asked if they wanted to retire and if they expected to be retired. Some of their retirement plans were obtained, including the sources of income they would have. In cooperation with the State Department of Health, an inventory of their health resources was obtained and many other items of importance were covered.

The second survey sampled persons 65-74. Their work histories, skills, and health were also noted. Careful attention was paid to their employment since the age of 65. Those who were not working explained the circumstances under which they left work. Those who kept on the job gave their reasons for doing so.

The third survey covered the policies and practices of employers and organized labor regarding the

employment, retention and retirement of older workers.

Obviously research is not fruitful unless it is followed by action. We might have a complete record of the hopes and aspirations of older people in Meriden but it would be useless unless something could be done to bring these dreams closer to realization. I am pleased to note that a Citizen's Committee on Aging has been established in Meriden. It is planning to review the findings of the State Commission and to take such steps as it can to bring about a fuller utilization of the skills and resources of older people.

I do not need to stress with citizens of your interest and experience the size of this growing problem as it affects Connecticut and our nation. Today nearly one of every five persons in our State is 55 years of age or more. At the turn of the century only one person in eight was 55 and over.

Moreover, whereas in the predominantly agricultural society of fifty years ago more than 60 per cent of our older men could get employment, in today's industrialized economy the proportion has fallen to approximately  $33\frac{1}{3}$  per cent.

We in Connecticut already have a higher proportion of persons 65 and over than in the country as a whole. And the proportion has been increasing fast. Between 1940 and 1950 person 65 and over grew in number at a rate which was more than twice as much as the rate of increase of the general population of our State. At the present rate it is estimated that by 1960 there will be nearly a quarter of a million persons 65 and over in our State.

I do not need to dwell on the reasons for this growing disparity, principal among which are the marvelous advances made in medical science. Nor do I need to point out that the problem of utilizing the skills and experience of our older citizens would be immensely complicated if, as we all devoutly desire, a durable peace is achieved in our time. Such a peace might, within a relatively short time, release back to peacetime pursuits many thousands of younger men and women, thereby reducing, for a time at least, general employment opportunities.

We must not impose enforced idleness upon our older citizens. To do so would not only be to subject large numbers to a feeling of chronic frustration but it would be a great loss of human resources. As Governor Lodge has said, there are important ex-

pectancies in life besides mere existence. Our medical victories which have done so much to raise life expectancy in this country will have little meaning if our people, in living longer, do not have a chance for reasonable happiness and usefulness.

It is a fine thing that the Connecticut Health League with its representation from more than thirty-five state-wide agencies and organizations should come together as you have done in a confer-

ence on the problems of the aging. Your discussions yesterday and today and your thinking along lines which will lead to constructive action should give renewed confidence and determination to all who are working for the betterment of the life of our older population. In meetings of this sort you do a real service to Connecticut, and particularly to our older citizens, who through your interest and enthusiasm have new cause for deep satisfaction.

## DOES YOUR PATIENT COME FIRST?

NORMAN H. GARDNER, *East Hampton*

FOR some time there has been more and more apparent in this country, nay in the world, a tendency to place the job to be done secondary to the pay check. Nothing could be more dangerous. This country was made great by those who were determined to do a better job, and who worked with all their hearts to accomplish it. You must remember these men had much to lose personally. The Declaration of Independence and the Constitution were fashioned with loving care by men who took pride in making them the greatest documents of their time. They built a new nation which became strong because they built well. Likewise, the carpenter, the bricklayer, the blacksmith took great pride in what he did.

The medical profession has a proud heritage which goes back to ancient times. In days gone by the doctor was looked up to with profound respect, almost reverence. He was a healer without much specific medicine and with few tools. But he put his whole heart and soul into his patient. When he walked into the sickroom, Faith and Hope were at his elbow—Charity was probably looking over his

shoulder, too. Devotion has always been one of the most common characteristics attributed to the medical profession. Devotion, and the ability to do great things with few tools if need be. We must continue to keep this ideal fresh.

I am somewhat distressed by the tendency of many to be so concerned with the economics of medical practice. I fear that such concern may lead others to the conclusion that medicine is not so much a profession as a trade. I think it behooves us all to do our utmost to maintain the standards of our profession at the present high level, keeping it always as our purpose to practice better and better medicine, knowing that increased perfection is bound to bring its reward.

We are truly a county society working together. I hope we all continue to have faith in each other. Faith that the other fellow is doing his best just as we are. Faith that the other fellow is loyal to the ethics of our profession the same as we are. Such faith must serve to reassure us all that, no matter how dark it seems, we are all going along the road together. We never walk alone.

*From Retiring Address of President, Middlesex County Medical Association delivered at Middletown, April 8, 1954*



## BACKING INTO SOCIALIZED MEDICINE

HOWARD BUFFETT

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The Author. *Former Representative to the U. S. Congress from Second Nebraska District*

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SOCIALIZED medicine ought to be a dead issue in America. In a number of elections its advocates have taken repeated shellackings, to the point where candidates for office hardly dare mention it. This situation is testimony to the political effectiveness of the doctors who fought socialized medicine, as well as to the fact that Americans will reject any socialistic proposal that is properly labelled; that is why the word "socialism" is assiduously avoided by its avowed proponents, like the New Dealers or the Americans for Democratic Action.

Nevertheless, we are edging towards socialized medicine, whether we want it or not. We are being dragged into it as a result of our attempt, since Pearl Harbor, to meddle in the affairs of the world. We are backing into it by way of militarism.

Out of World War II emerged over fifteen million American veterans, each with a lifetime claim on the government for free medical care—subject to some conditions. Then there are about 3,700,000 men and women now in uniform who have a "plus" claim on society for medical attention; the "plus" is the inclusion of their dependents and families in the subsidy. To be exact, the "plus" is not entirely free, for the dependents are required to pay certain modest charges for such medical services as they receive.

Altogether, there are almost 20,000,000 Americans, mostly on the underside of fifty, who enjoy this special attention.

The government has sought to lessen this continuing strain on its budget by attaching some technical restrictions to the use of the privilege. The

regulations call for dividing all medical cases into two broad classifications, service connected and non-service connected disabilities. A service connected disability can be positively traced to service duties and entitles the veteran to free and unlimited medical attention for the rest of his life. Nonservice connected disabilities are treated free in Veterans' Hospitals only if the patient signs an application in which he declares his inability to pay. His signature is final; it is not checked or questioned in any way. The idea is to protect the ailing veteran from embarrassment.

Naturally, most postservice health troubles are postservice developments; we all acquire more miseries as we get older. Also, like most of us, veterans have their financial troubles. It is not strange, therefore, that a recent survey came up with the statistics that 64 per cent of veteran hospital beds were occupied by patients suffering from nonservice ailments. That left only a third of the available beds for service connected cases, which explains why so many deserving veterans were kept on the waiting list. Quite a headache for the Veterans Administration.

The financial and medical difficulties arising from the claims of veterans already on the rolls are as nothing to what looms ahead. Under the Selective Service law, about 900,000 young males are conscripted each year, and conscription automatically entitles them to medical care for the rest of their lives—according to regulations. Should Selective Service, often referred to as sugar-coated Universal Military Training, be converted into full-fledged UMT, in a comparatively few years at least half the nation's population—not counting dependents—would have a claim on Uncle Sam, M.D. Since UMT

would be a continuing process the claim on said doctor's services would grow and grow.

Nor does the problem stop there. As the government siphons off the medical personnel needed for sick veterans or soldiers in service, the talent available for the civilian population diminishes. The VA now employs 7,000 doctors regularly and an equal number on call. This creates an artificial shortage of doctors for the rest of the population, a shortage that is not relieved by the medical schools simply because more and more of their graduates are drawn into the services, either voluntarily or via the draft.

This false scarcity of doctors creates the very conditions which the advocates of socialized medicine decry. Following the law of supply and demand, the fees of the fewer available doctors rise. And as a matter of necessity, their offices are overcrowded and their examinations are often forced to be hasty and perfunctory. Thus the inflammatory charges of the socialists acquire substance—if one overlooks the cause of the condition, which is the absorption of a large part of our medical profession by the military.

Yet the facts indicate that the hullabaloo about the shortage of doctors in America is just hullabaloo. In 1940, before the war, there was no shortage. In fact, there was a shortage of patients, for many young and well trained doctors were finding it difficult to establish practices. What then happened to create the present apparent shortage?

In 1940 there were 175,382 medical doctors in the United States. By 1952 the number had increased to 211,680, a gain of 36,298. To be sure, the population of the country had increased by 15 per cent—but the doctor population had increased by 21 per cent.

Where are all these doctors? As stated above, a good portion of them are in the employ of the Veterans Administration. But, many more are in military uniforms, stationed wherever American troops are stationed. The Army has one doctor for every 275 men and women in the service. The Navy personnel seem to be more fragile; they need a doctor for every 195 men in uniform. The Air Force, somewhat less demanding, gets along with a doctor for every 315. While those in combat areas could understandably be in need of such liberal medical service, most of the military forces are, thank God, not so occupied, and on the whole they constitute the healthiest segment of our entire population.

As for the rest of us, we must get along with one

doctor to 710 possible patients. Whether that is adequate we do not know. But we do know that many of our small communities cannot secure permanent doctors; and we do know that the available civilian doctors are carrying a heavy load. None of us, not even the overworked doctors, would complain about this condition, if it were created by the need of medical attention on the battlefield, or even in the service hospitals. There is a suspicion, however, that the large ratio of doctors to men in uniform is in line with the program of those who would collectivize America.

A government that conscripts its youth is under obligation to provide them with adequate medical care, regardless of any shortage of doctors for the civilian population; no one can quarrel with that. And it is easy to see that the claim of veterans to medical help under varying circumstances also has justification. But, when we think of the likely impact of this situation on the future of private medical practice, the problem takes on an aspect quite unrelated to the duty of the country to its soldiers.

Not only will the soldier come out from the service with a firm conviction that he is entitled to all he can get from the government, but the doctors who have had a taste of regimented medicine, with its freedom from responsibility to the patient, will most likely favor a continuance of the sinecure in civilian life. Not having had any experience with private practice, he will not understand its superiority and will not therefore be inclined to fight against socialized medicine. The struggle against socialization has been waged by American doctors who had built up practices in the hard, competitive way. Their minds had not been socialized. But the breed of doctors in the offing will have had a different training.

The doctor who enters the army directly from medical school, or after his internship, knows nothing but bureaucratic medicine, and has no experience by which to measure its disadvantages. Just as the young graduate who goes to Washington immediately after he receives his diploma soon makes a perfect mental adjustment to statism, so the doctor in uniform learns how to get along by pleasing his superiors (not his patients), and how much easier it is to make reports than diagnoses. Besides, the regularity of the pay, though inadequate, is an immediate inducement that offsets the promise of the future in private practice. Why hang up a shingle and wait for patients? The government has lots of



them. And why fret about fees and collections? The monthly check from the government is always good.

So then, socialized medicine can slide into the American way of life without any new legislation. This would be all right to those who are hell bent for socialism. To those of us who have always known that militarism and socialism are related, the situation is dark; unless we can get rid of militarism we cannot prevent the coming socialism.

Perhaps the solution of this problem lies with the doctors who know of the dangers to medicine, both as a science and an art, in socialization. They have thus far put up a good fight, and maybe they can figure out a maneuver to prevent the destruction of the profession by the flank movement from militarism. Perhaps the young doctors can be taught that regimented medicine is bad for them and the country.

To those who refuse to see the danger in the present trend, and who view the situation as a temporary postwar phenomenon, I offer a bit of history. The Civil War ended in 1865. But the largest number of pension recipients was not reached until 1915, 50 years later, when 691,606 Civil War pen-

sions were being paid. The peak of expenditure for Civil War pensions was reached in 1921. From this experience it is fair to conclude that the medical demands arising from our two World Wars will grow with the years, and will continue to provide the advocates of socialized medicine with plausible argument.

The veterans are not to blame for this situation. They bear little or no responsibility for it. When they were drawn into the bloody and futile overseas ventures, they were entirely too young and inexperienced to pass judgment on the policies that disrupted their lives, or to understand what the consequences of these ventures would be. One can express disappointment, however, that their leadership has not supported the small band of patriots in and out of Congress who have resisted the drainage of our economy to the point where future payments to widows, orphans and wounded will be of questionable value. The continuing wastage of our wealth since World War II, by way of handouts, while working into the hands of our socialist minded, must in the end weaken the nation's ability to discharge its solemn duty to the veterans.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

30th Anniversary Session of Clinical Congress

One of the requirements for maintaining membership in the Academy of General Practice is the fulfillment of a specified number of hours of postgraduate study. The specialist has long since found this a necessary adjunct to a successful practice. Such an opportunity has been offered annually at our own medical school in New Haven since 1924, except for the war year of 1945. The chairman of the committee for the 1st Connecticut Clinical Congress, David Chester Brown, and the first secretary of that same committee, Milton C. Winternitz, will be remembered as men of accomplishment and of dynamic personalities. One represented the State Medical Society; the other, the Yale University School of Medicine. Together they were symbols of that cooperative endeavor "to bring to physicians of the State, either through members of the State Society or through recognized authorities in medicine from other States, such information as will be beneficial to them concerning the cause, diagnosis, prevention and therapy of minor and major illness" which has characterized the Clinical Congress over these thirty years.

Perusal of the program for the 29th Clinical Congress this month will reveal how well the committee has followed out the original purpose of the Congress. Seven of the speakers are our own members,

ten come from neighboring Boston and ten from New York, and the remaining nine hail from as far south as Richmond and as far west as Milwaukee. The subjects covered give evidence of the recent developments in the practice of medicine and some of the problems peculiar to this decade. For example, the gastrointestinal complications of antibiotic therapy have assumed a place of major importance and will be discussed. Cervical pathology has been found to account, some say, for forty per cent of sterile matings. Cardiac arrest with modern methods of treatment for this critical condition should interest every physician. Arthritis is assuming an ever increasing importance with the extended life expectancy of man. Cardiac operations offer one of the most amazing fields of development. Radioactive iodine has come into its own. The treatment of alcoholism has assumed new importance, especially in Connecticut. Discussion of these and many other phases of medical and surgical practice will be presented by experts.

There is no question but that our Clinical Congress supplies a need. At one time occupying two days, then three, and now condensed into two again, no physician in Connecticut can well afford to miss its sessions. We owe a debt of gratitude to our efficient committee, to those who will preside at the sessions, and to our speakers. Your presence at the Congress will give evidence of your interest in the welfare of your patients.



## The Role of the Anesthesiologist

With the development of the specialty of anesthesiology medical practice has acquired a valuable addition to its team. Formerly one thought only of the anesthetist when ether was to be poured in the operating room. In this issue's section on Progress in Clinical Medicine Dr. Zeldis discusses the many functions of the trained anesthesiologist in the modern hospital. Not only are there situations in which fine decisions can be made as to the selection of the most suitable type of anesthesia for that operation and that patient, but there are many opportunities for the use of his techniques in aiding the internist. Last, but not least, is the problem of resuscitation of the new born, passed from the obstetrician to the nurse, to the pediatrician, back to the obstetrician, and now to the anesthesiologist. Not all hospitals can boast trained anesthesiologists in the delivery rooms. Many still find the services of the nurse anesthetist not only a necessity but a valuable adjunct to the administration of obstetrical anesthesia. But even the faithful nurse anesthetist and the delivery room nurse, yes, and the obstetrician too, have found that the techniques of the anesthesiologist are of value in this age of obstetrical analgesia on the one hand and "natural childbirth" on the other.

We all have much to learn. The modern anesthesiologist is making a valuable contribution to the art and science of medicine. Fortunate indeed are the surgeons, internists and obstetricians who have available his services for their patients.

## Misdirected Effort

*The Yale Law Journal* is not a publication that we read regularly but the May 1954 issue, published in July, is not to be passed over. It contains an eighty-four page report, entitled "The American Medical Association: Power, Purpose and Politics in Organized Medicine." It is a monumental piece of work but in spite of its 759 foot notes it is on a rather shaky foundation. Perhaps it is not necessary to comment upon it but the fact that it is in print and will undoubtedly be quoted and referred to seems provocation for notice here. Yale University News Bureau, the official publicity agency for the University, has recently sent out a news release on the article that quotes largely from statements made by George Lull of the American Medical Association. We agree completely with Dr. Lull's statements and could add to them. "It took the students two years

to make the study," he said, "but they took neither the time nor the trouble to interview AMA officers or staff people at the Chicago headquarters to get their facts correct." It may also be said that galleys of the article were submitted to the State Medical Society but it was already in type and comments and corrections could not be effected. Many important sections contain completely false and erroneous information.

The article says that "no other voluntary association commands such power within its area of interests as does the AMA. It holds a position of authority over the individual doctor, wields a determining voice in medical education, controls the conditions of practice, and occupies a unique position of influence in shaping government health policies." "Doctors who defy AMA authority," the authors argue, "may be subjected to professional ostracism, which could cut them off from patient referrals and consultations, deny them advancement in hospitals, or bar them from professional appointment." This observation is false as Dr. Lull states, "the American Medical Association has almost no authority over individual physicians. It is the county medical society that disciplines members who are guilty of unethical practices."

After dozens of pages of distorted opinion, the law student authors make several gratuitous recommendations to curb the importance of the AMA.

First, to protect the individual doctor from unreasonable exercise of organized medicine's authority, the importance of society membership should be de-emphasized in order to mitigate the severe consequences of its disciplinary powers. As one step, the writers suggest that this could be done by insuring availability of hospital privileges to non members.

Commenting on this statement, Dr. Lull said, "the AMA has no control whatsoever over hospital staff appointments which are all made by the local hospital Board of Trustees."

The second recommendation is that organized medicine should be divested of its control over the nation's supply of doctors. This step could be accomplished by federal aid to medical schools without impairing AMA powers to set educational requirements and to inspect these schools, according to the authors.

This accusation is "false and malicious," said Dr. Lull, "the AMA has no control over the nation's supply of doctors. The Yale Medical School Admis-

sions Committee and all similar committees throughout the United States determine the number to be admitted. The AMA has nothing to do with control over the supply of doctors."

The student authors also recommend that "legislatures should divest state medical societies of their control over the formation of new methods of providing low cost prepaid care. At present, state statutes requiring approval or participation by the medical society or a majority of the doctors have foreclosed experimentation in solving pressing medico-economic problems."

Had these young legal minds studied the Connecticut Statutes more carefully (Chapter 253), they would have learned that in this State, at least, there is no such restriction. "Any number of persons not less than seven, all of whom shall be residents of this State, may form a corporation, under and in conformity with the provisions of this chapter, for the purpose of establishing, maintaining and operating a non-profit medical service corporation." Representatives of this Society wrote and urged the passage of this Act in 1939.

Finally the authors say, "the AMA should provide a forum for dissenting opinions and conflicting viewpoints. New ideas, which the AMA has accepted, have been forced upon it." One wonders how far the authors went in exploring the activities of the Council on Medical Service and the Council on Rural Health.

Despite the obvious labor that went into this study, it is peculiarly unrewarding. We would be among the first to admit, because of intimate understanding and historical perspective, that the AMA is not perfect. Also, for the same reasons, we would welcome unprejudiced comment and well informed opinion from objective critics. It is unfortunate that this time consuming survey did not turn out to be that.

## Radiation and Herpes Zoster

There is little doubt that herpes zoster is due to a virus closely allied to that of chicken pox, though there are still those who are skeptical concerning the actual isolation of the etiological agent. There is a growing belief in some quarters that the disease occurs as a secondary manifestation just as herpes simplex is particularly frequent after malaria, pneumococcal pneumonia and meningococcal meningitis. Indeed, herpes zoster has been described occasionally after malaria and also after tularemia and there is

some evidence that the virus of herpes simplex may occasionally produce the clinical picture of zoster.

Recently Schmidt and Thierfelder\* who believe that the virus of herpes zoster produces a lesion only after a ganglion or the afferent tract of the spinal column has been damaged by some noxious agent, have pointed out that irradiation with x-rays may be followed by zoster. They record the histories of nine patients suffering from various diseases in whom radiation therapy was followed by herpes zoster on the side and in the region of the irradiated segments. They note that the latent period between the x-ray treatment and the development of the zoster was much shorter than that observed by Ellis and Stoll in patients in whom the disease followed trauma. They also observed that the irradiation in the case of non-malignant lesions involved relatively small doses and that in patients with carcinoma, of whom there were six, no toxic action of the cancer was involved, there had been no surgical intervention, and there was no evidence of metastasis to the spinal column. After their report was prepared they observed eight additional patients, six of whom had carcinoma of the breast, in whom x-ray therapy was followed by herpes zoster.

These observations bring up several questions: Can herpes zoster occur as an occupational disease in miners of pitchblende? Is it recorded after exposure to radium? Has it occurred after the use of isotopes? The question is worthy of further study as zoster is occasionally followed by encephalitis and, especially in the elderly, by intractable neuralgia.

G. B.

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\*Abstract Jour. Amer. Med Assn., 1954, 155:870.

## The Beaumont Memorial

On July 17, 1954, on an island situated between two of this country's Great Lakes, there occurred an event which should interest every Connecticut physician. From funds collected from the doctors of medicine of the State of Michigan there was erected a shrine to William Beaumont, M.D., whose dramatic experiments on human digestion in a "living laboratory" earned him the distinction as the first American physician to make an enduring contribution to medical progress. Coming as a climax to more than a decade of planning and building, the Beaumont Memorial was presented as a gift to the people of Michigan to become a permanent landmark in Mackinac Island State Park.

The Beaumont Memorial is a reconstruction of



the American Fur Co. retail store where Alexis St. Martin, 18 year old French-Canadian voyageur, was accidentally shot on June 6, 1822, and where Dr. Beaumont first ministered to the gravely wounded youth. St. Martin was left with a permanent opening into his stomach, which permitted Dr. Beaumont to learn for the first time in medical history the fundamental secrets of the digestive process by direct observation and experimentation.

Built on the actual foundation of the old building, the shrine is being fitted out as a replica of the original store, with one section reserved as a medical museum containing surgical instruments and other mementos from the early 1800's.

The site was purchased by Parke, Davis & Co. of Detroit. Another leading pharmaceutical house, Wyeth Laboratories of Philadelphia, has presented its famous oil painting of Dr. Beaumont and St. Martin by Dean Cornwell to hang in the memorial. Michigan doctors of medicine alone are responsible for the rest, grateful as they are for various offers from other business firms.

The diary that Dr. Beaumont kept, recording his observations under the heading "K 6th," was presented by surviving members of his family. It is on display in a little one and a half story stone and frame building.

There also are the crude instruments with which he worked, his watch, his spectacles case, the razor with which he shaved and other memorabilia pertinent to the life of the Eighteen Twenties and Eighteen Thirties.

The original furniture of the living room of the American Fur Company's trading post, the company from which came the John Jacob Astor fortune, has disappeared but it has been faithfully reconstructed from descriptive notes left by the doctor and others and from period pieces found.

The business office will be finished soon. The large room in the upper story contains the exhibits of Dr. Beaumont's life. More than \$50,000 has been spent on the project.

In accepting the memorial to Dr. Beaumont, Michigan has honored a man who typifies in several ways the traditionally high standards of the medical profession in America. Dr. Beaumont, in various stages of his life, was representative of the devoted medical practitioner, the tireless research worker, the heroic army doctor, and, in his later years, the skillful medical teacher.

Connecticut may point with pride to this recognition of one of her own sons, born in the rural

community of Lebanon. We join the physicians of Michigan and Dr. Otto Beck, chairman of the Beaumont Memorial Committee, when he stated "The highest praise we can give is to say that Dr. Beaumont's life fulfilled the ideal with which he set out, and which he so well expressed in this sentence: 'Truth, like beauty, is when unadorned, adorned the most, and in prosecuting these experiments and inquiries, I believe I have been guided by its light'."

### \$25,260 "Unrestricted"

The following editorial is reprinted from the  
*New Haven Register*

Any with an interest in personal or community health—and who is not?—must look with vast approval on the \$25,260 grant just made by the National Fund for Medical Education to the Yale University School of Medicine. There are no restrictions on the use of these funds. This approval must broaden in extent with realization that this amount is but part of a much larger \$2,176,904 series of grants made to each of the nation's 74 four year medical schools and its six two year basic science schools.

The cause of a free, unregimented pursuit of medical knowledge and the search for new avenues toward better national health, has in this amount been materially advanced. This is a splendid thing that is being done. Its splendor gains added luster with realization that it is being done in the traditional way and the proper way.

A valued road block is thus placed in the path of the armies of socialized medicine and the would be aggressors who would impose state-financed, state-supervised and state-controlled medicine on the false grounds that our existing private medical schools are not doing their job and cannot hope to do their job.

Here, in these funds provided through the Funds Committee of American Industry and the American Medical Education Foundation, lies that hope.

Note should be taken of the fact that the current grants bring to some \$6,971,045 the funds thus awarded to our medical schools. This is not to say that such an amount will solve all the medical schools' problems, or even more than begin to head them toward solution. Ever mounting costs and rising demands for services continue as heavy problems and weigh heavily in the financial sense.

Yet ultimate solution can be classed as no forlorn hope so long as interested, generous and responsible industrial-medical freewill organizations continue to give evidence of these qualities in such concrete terms.

## THE PRESIDENT'S PAGE

**I**t is probable that the field of medical knowledge has expanded more in the past forty years than in the preceding three centuries, and the rate of growth has been ever faster. It is possible that the newer sciences of electronics and nuclear physics have grown with equal rapidity, but it is difficult for a mere physician to believe that practitioners in those fields have to cope with the vast accumulation of knowledge and the rapid additions to it that the modern doctor of medicine must try in vain to digest. It is not surprising that medicine found it necessary to imitate the lowly ameba by dividing and redividing, each new body thus created subdividing still further. So today instead of a broad division into internal medicine and surgery we have a large number of subspecialties in each, many of them officially recognized and others awaiting recognition.

This inevitable development was discussed with great humor and insight last year by Dr. Barry Wood, who contrasted the professor of medicine thirty years ago with his counterpart of today. The earlier one, as Dr. Wood reminds us, was regarded as the embodiment of all knowledge and wisdom; his word as to diagnosis and treatment was final and unquestioned; he knew, so far as one man could, the whole field of medicine. But today the chief of the department of medicine in a medical school is analogous to the conductor of a large and complex symphony orchestra. He tries to know enough about each special instrument or group to maintain responsibility, cooperation, and timing, but recognizes that each artist following his leadership has greater knowledge of his own field than the conductor can hope to acquire. Thus it has become commonplace knowledge that no physician today can hope to absorb and utilize all the important knowledge in any one field of the medical sciences, since each special field expands with great rapidity.

The point need not be labored further. It is mentioned chiefly to emphasize that the need of postgraduate education is greater today than ever before. While no physician can hope to keep fully abreast of all advances, it is possible to become familiar with the most important ones within a reasonable time of their first announcement. It may not be strictly true, as some have stated, that the simplest way to do this is to read the newspapers, *The Saturday Evening Post*, and *The Readers' Digest*, but it is certainly true that such publications have done much to stimulate doctors and to inform their readers about medical topics.

There are better methods than reliance upon newspapers and popular magazines, however ably these are edited. One will be exemplified within a few days by the annual Connecticut Clinical Congress. This will be its 29th session, which in itself is evidence of the high place it occupies in the esteem of physicians in New England and nearby states. The program this year is as interesting and diversified as in the past, most of the speakers are of national renown, and the arrangements have been made in the light of long experience and the recommendations of those who have attended many sessions. It will provide a fascinating and painless way of learning the present status of controversial subjects and the most important developments in many fields of medicine and surgery.

Our State was one of the pioneers in this form of postgraduate medical education. We believe it has maintained its leadership. But the Congress will not continue to flourish unless it is supported by the attendance of those for whom it was developed—the practising physicians of Connecticut, New England, and other northeastern states. A great deal of careful planning and devoted effort have been spent upon its preparation. There are few physicians who will not find profit and pleasure in many parts of the program. All who can possibly do so are urged to set aside September 15 and 16 in order to participate in one of the most important educational activities of the Society.

H. M. Marvin, M.D.



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### Council Meeting

The monthly meeting of the Council was held in the Conference Room at the Windham Community Memorial Hospital, Willimantic, Connecticut on August 5, 1954. The meeting was called to order by the chairman at 3:30 P. M. There were present in addition to the chairman, Dr. Danaher, Drs. Marvin, Stringfield, Couch, Barker, Weld, Murdock, Gildersleeve, Gibson, Feeney, Fincke, Gallivan, Ursone, Tracy, Russell, Labensky, Ottenheimer, Clarke, Buckley, Dwyer, Archambault, Gilman. Guest, Mr. James Burch. Absent: Drs. Flaherty, Gens, Walker.

1. Replacement of two members of the Committee on Public Health in place of Henry Bunting, deceased, and Charles A. Murphy, resigned, was considered.

2. Resignation of Morris P. Pitock as chairman of the Committee on Student Members was accepted with regret. (AMB 8/5/54—"B".) No designation was made for another member of the committee to serve as chairman and the secretary was instructed to confer with William E. Bloomer, New Haven, concerning the objectives of the committee and if he would be willing to accept its chairmanship.

3. Cole B. Gibson was nominated as Director-at-Large on the Board of Directors of the Connecticut Tuberculosis Association for an additional term of two years.

4. A request was presented from the Connecticut Tuberculosis Commission that the Society appoint a Medical Advisory Committee to the Commission. (AMB 8/5/54—"C".) This proposal was approved unanimously and nomination of members to serve on the Advisory Committee was proposed. After discussion it was concluded that additional consideration be given to the make-up of this committee. To that end the chairman of the Council was authorized to appoint a special Subcommittee to confer

with Paul Phelps, medical director of the Commission, in regard to membership on the committee. The chairman appointed Dr. Gildersleeve, chairman, Walter I. Russell and Stanley B. Weld, with instructions to it to present its nominations to the Council at its next meeting.

5. It was voted to allot \$100 to the Medical Advisory Committee to the State Department of Welfare for its expenses during the current year.

6. President Marvin presented a proposal from the Connecticut Heart Association in regard to arrangements for patients to obtain penicillin for rheumatic fever prophylaxis at cost. (AMB 8/5/54—"D".) The following action was taken:

1. That the proposal of the Connecticut Heart Association to promote actively a program for the prevention of rheumatic fever, in accordance with the procedures recommended by the American Council on Rheumatic Fever and Congenital Heart Diseases, receive the endorsement of the Connecticut State Medical Society.

2. That the Connecticut State Medical Society appoint a representative to meet with the representatives of the Connecticut Heart Association and the Connecticut Pharmaceutical Association in the development of plans to implement this program.

3. That Barnett P. Greenhouse, New Haven, be designated the Society's representative as provided in paragraph 2.

7. The following action by the Committee on Public Relations at its meeting on March 18, 1954 was discussed: "Dr. Root reported that the circularizing of physicians by the American Medical Association urging support of the Bricker Amendment had aroused some resentment because of the involvements and changes attendant upon the issue. Other members of the Committee reported similar reactions. Following discussion, it was voted to record disapproval of the action and to request the Society's

Council to consider the advisability of filing a protest with the American Medical Association." (AMB 8/5/54—"E".)

No action was taken on this recommendation and the secretary was directed to inform members of the Committee on Public Relations that the urgent stand taken by the American Medical Association was for the protection of American medicine and had no political implications, but was to protect medical service in this country from the imposition of nationalization made mandatory by covenants in conventions and treaties without Congressional approval.

8. A resolution adopted by the Committee on Public Relations at its meeting on March 18, 1954 that the Council consider the possibility of sponsoring or otherwise endorsing a course in Medical Economics and Public Relations and Allied Subjects for medical students at Yale University School of Medicine was approved and the secretary was instructed to confer with Dean Lippard of the Medical School as to how this proposal could best be implemented. (AMB 8/5/54—"F".)

9. A further inquiry had been received from the Committee on Public Health asking the Council to redefine and clarify the areas of responsibility in the field of chronic illness that belonged to the Committee on Public Health and the Committee on Chronic Illness. (AMB 8/5/54—"G".)

In relation to this subject, the secretary presented a joint request from Colonel Raymond Watt of the Veterans Home and Hospital Commission and Sidney Shindell, medical director of the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, requesting that the Society designate its Committee on Chronic Illness as the Medical Advisory Committee to these Joint Commissions. The Council approved this request and the Committee on Chronic Illness in the future will be known as the Medical Advisory Committee to the Joint Commissions (Veterans Home and Hospital Commission—Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm).

In view of this change in status, it was the opinion of the Council that there should be no further conflict in understanding of the respective responsibilities of the two committees involved.

10. Dr. Marvin reported that a member of the society who had been invited to become the Literary Editor of the JOURNAL had declined and at present

no candidate could be proposed, but that consideration of an appointee would continue. (Reference AMB 2/11/54 "B".)

11. Dr. Tracy reported that the Subcommittee on Revision of the By-Laws concerning Alternate Councilors, Speaker and Vice-Speaker of the House of Delegates, had not yet had a meeting, but that he had been collecting information on the subject and it was expected the committee would meet in September. (Reference AMB 2/11/54—"C".)

12. Dr. Gallivan reported that the Subcommittee to Investigate Retirement Program for staff members had not met since its appointment, but that plans in operation elsewhere had been obtained by the secretary and made available to the committee which expected to meet in the near future.

13. It was reported that Dr. John M. Freiheit had agreed to serve as liaison officer between the Society and the Woman's Auxiliary in the arrangement of the Art Exhibition.

14. Dr. Marvin presented the Annual Invitation for the Society to sponsor the New England Diabetic Institute to be held in Boston later this year and approval of such sponsorship was voted.

15. Three student members were elected:

Lester M. Cramer, Hartford

Intern at Hartford Hospital—June 1955

Pre-Med: Columbia College of Physicians & Surgeons

Parent: Samuel Cramer

Edward J. Granowitz, Greenwich

University of Basel—Faculty of Medicine—  
Class of 1957

Pre-Med: Wilmington College

Parent: Morris Granowitz

Charles Vassallo, Jr., Fairfield

Tufts College Medical School—Class of 1957

Pre-Med: Tufts College

Parent: Charles Vassallo, Sr.

16. The chairman was authorized to appoint a Budget Committee to consider the Budget for year 1955 and confer with the executive secretary and Mrs. Lindquist. The chairman appointed Dr. Couch, Chairman, C. Louis Fincke, John N. Gallivan and Edward J. Ottenheimer.

17. It was voted that the next meeting of the Council would be held on Thursday, September 16, commencing with dinner following the adjournment of the Clinical Congress and the business meeting following in the evening.

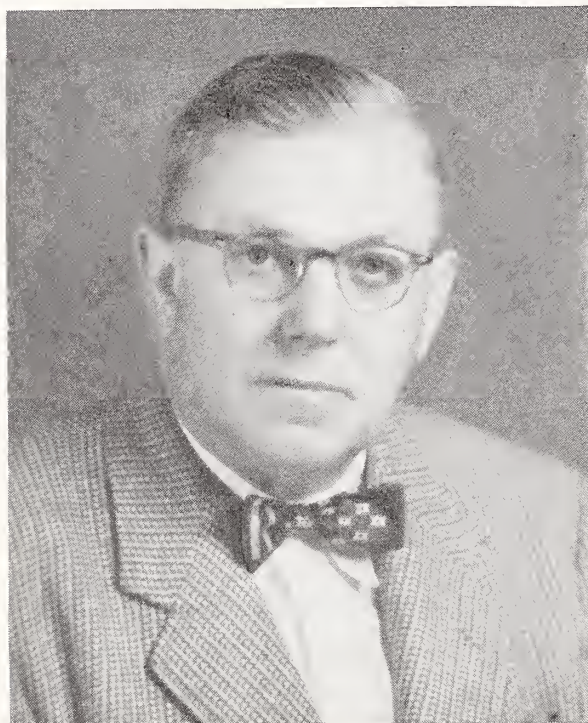


The meeting adjourned at 6:00 P. M., following which the gentlemen of the Council were the guests of Dr. Edward J. Ottenheimer for a Clam Bake at his residence in Windham Center.

### Meetings Held During August 1954

- August 2—Conference Committee with Pharmaceutical Association
- August 4—Advisory Committee to Welfare Department
- August 5—Council Meeting
- August 11—Executive Committee, Connecticut Medical Service

### Special Appointment for Dr. Horton



Dr. William H. Horton, executive director of Connecticut Medical Service, the nonprofit surgical-medical care plan, has been invited to represent National Blue Shield in joint discussion with Blue Cross on the problems of long term illness.

Dr. Horton will be the physician member on the Committee, which soon will take up discussions on how voluntary prepayment plans can best provide adequate coverage of medical expenses incurred by catastrophic types of illness.

In response to growing public demand, the Blue Shield surgical plans and the Blue Cross hospital

plans are seeking ways and means for making available to the general public coverage of extraordinarily long disabilities, in much the same manner they have been meeting the demands of the more common short-term illnesses.

Dr. Horton recently served on the Committee on Financing of a special National Conference on the Care of the Long Term Patient. The three day conference, conducted at Chicago, was sponsored by the National Commission on Chronic Illness, an independent national agency founded jointly by the American Hospital Association, the American Medical Association, the American Public Health Association and the American Public Welfare Association.

Meanwhile, on July 27, Dr. Horton was one of the principal speakers at the Blue Shield-Blue Cross Executives Training Program, at the University of Michigan. He presented the case for Service Benefits in a debate on the relative merits of Service Benefits and Indemnity Benefits.

The debate outlined the basic difference between the two approaches to prepayment, illustrating their effect on plan administrations, plan relationships with the medical profession and the general social objectives to be served.

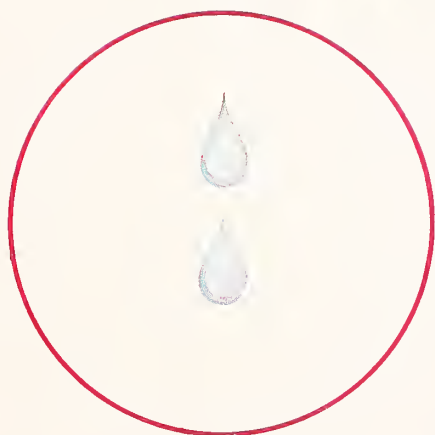
### Connecticut Blood Program

After four years of operation of a highly successful blood program in the State of Connecticut, it is well on this anniversary to cast our thoughts backward and consider our humble beginning.

On December 14, 1941, a letter was written by the late Dr. Donald B. Wells of Hartford to the Hartford Chapter asking for the assistance of the Chapter in establishing a bank for blood and plasma for the day-to-day and emergency needs of the residents of Hartford County. This proposal sponsored by Hartford physicians met with chapter approval. A special subscription of \$14,000 was raised by various organizations in Hartford and donated to the Hartford Chapter for the establishment of such a bank. The original donor station was located midst the roses at the Pond House in Elizabeth Park. During the months of August to October 1942, 5,700 pints were collected at a cost of approximately \$18,000. Part of this blood was converted into frozen plasma and is still sorted in a deep freeze warehouse in Hartford. This plasma was inspected by representatives of the National Institute of Health within the

2 drops  
open airway  
in 2 minutes

**Privine<sup>®</sup>**



Rapid vasodilating action of Privine relieves nasal congestion in a minute or two—effect lasts for hours.

No interference with ciliary activity or other mucosal function.

Isotonic, pH compatible with nasal fluids.

No epinephrine-like excitation.

Privine 0.05% Solution in 1-oz. bottles with droppers and in pints.

Privine<sup>®</sup> hydrochloride  
(naphazoline hydrochloride CIBA)

**C I B A**  
SUMMIT, N. J.



**new**

**9-city study**

**confirms value**

**of**

# **Pyribenzamine<sup>®</sup>**

**in ragweed hay fever**

In the summer and fall of 1953, nine prominent allergists, representing every section of the country except the West Coast, tested Pyribenzamine in a total of 832 patients with ragweed hay fever. The work of these men is significant because of its scope and because it is the most recent major study of antihistamines.

*Certain observations are particularly worth noting ...*



(PHOTOGRAPHS FROM A STUDY CONDUCTED BY GIBA)



**THE ALLERGIC PATIENT ... before and one-half hour after receiving PYRIBENZAMINE**





**... of the 832 patients who were  
given Pyribenzamine,  
only 84 did not obtain some  
degree of symptomatic relief.**

From this study and from previous investigations involving thousands of allergic patients, one fact is clear: Pyribenzamine gives the allergic patient unsurpassed benefit with antihistamine therapy.

**Pyribenzamine® hydrochloride**  
(tripelennamine hydrochloride CIBA)



Try Pyribenzamine — the most prescribed antihistamine — in hay fever, in every allergy susceptible to antihistamine therapy.

Pyribenzamine 25-mg. tablets (coated) and 50-mg. tablets (scored) both available in bottles of 100 and 1000.

**C I B A**





more  
blood  
to the  
periphery  
with

# Priscoline®

Increases blood flow to the extremities through a direct vasodilating effect on vessel wall, a sympathetic blocking effect, and an adrenolytic effect—

A valuable aid in the treatment of peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, and other trophic manifestations—

Priscoline hydrochloride available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Priscoline® hydrochloride (tolazoline hydrochloride CIBA)



**BILATERAL  
ARTERIOSCLEROTIC  
ULCERATION** in patient age 65.

At start of Priscoline therapy;  
ulcer, right leg,  $1\frac{3}{4}'' \times 1\frac{1}{4}''$ ;  
ulcer, left leg,  $\frac{1}{2}'' \times \frac{1}{2}''$ .

With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



**HYPERTENSIVE ISCHEMIC  
ULCER** of right leg in patient

age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA  
BY COURTESY OF R. I. LOWENBERG, M.D.,  
CONSULTANT IN VASCULAR SURGERY,  
CONNECTICUT STATE HOSPITAL,  
MIDDLETOWN, CONNECTICUT.

C I B A

## DISTRIBUTION OF BLOOD

		JUNE 1954			RECAPITULATION FOR YEAR 1953-54		
HOSPITALS		DISTRI- BUTION FROM CENTER	COL- LECTED IN HOSPITAL	TOTAL DISTRIBUTION	DISTRI- BUTION FROM CENTER	COL- LECTED IN HOSPITAL	TOTAL DISTRIBUTION
Bridgeport	Bridgeport Hospital	330		330	4,020	302	4,322
	Park City Hospital	32		32	280		280
	St. Vincent's Hospital	416		416	4,767	295	5,062
Bristol	Bristol Hospital	121		121	1,320	61	1,381
Danbury	Danbury Hospital	124		124	1,568	95	1,663
Derby	Griffin Hospital	95		95	912		912
Greenwich	Greenwich Hospital	128	2	130	1,429	57	1,486
Hartford	Cedarcrest Sanitarium	0		0	20		20
	Hartford Hospital	675	204	879	5,906	2,409	8,315
	McCook Hospital	97		97	1,074		1,074
	Mt. Sinai Hospital	151	27	178	1,184	399	1,583
	Rocky Hill Hospital	50		50	470		470
	St. Francis Hospital	449	40	489	4,373	806	5,179
Manchester	Manchester Hospital	100		100	1,169	65	1,234
Meriden	Meriden Hospital	157	40	197	1,945	107	2,052
Middletown	Middlesex Hospital	100	11	111	1,670	248	1,918
Milford	Milford Hospital	55	2	57	591	38	629
New Britain	New Britain Hospital	263		263	3,256	83	3,339
New Haven	Memorial Hospital	243		243	2,331		2,331
	New Haven Hospital	466	125	591	4,449	2,313	6,762
	St. Raphael's Hospital	270	87	357	3,587	1,260	4,847
Newington	Children's Hospital	6		6	167		167
	Veterans' Hospital	103		103	1,439	9	1,448
New London	Lawrence and Memorial Hospital	247	9	256	2,262	539	2,801
New Milford	New Milford Hospital	39		39	387		387
Norwalk	Norwalk Hospital	185	20	205	2,409	356	2,765
Norwich	Backus Hospital	181		181	1,476	159	1,635
	Uncas-on-Thames	37		37	453		453
	Norwich State Hospital				28		28
Putnam	Day Kimball Hospital	71	1	72	634	33	667
Rockville	Rockville City Hospital	29		29	288		288
Sharon	Sharon Hospital	45		45	538		538
Southington	Bradley Memorial Hospital	29		29	289		289
Stafford Springs	Johnson Memorial Hospital	33		33	380		380
Stamford	Stamford Hospital	214		214	2,405	226	2,631
	St. Joseph's Hospital	82	3	85	871	33	904
Torrington	Hungerford Hospital	143	11	154	1,458	66	1,524
Waterbury	St. Mary's Hospital	211		211	2,495	261	2,756
	Waterbury Hospital	231	20	251	3,101	626	3,727
West Haven	West Haven Veterans	210		210	1,531		1,531
Willimantic	Windham Community Hospital	77	12	89	817	185	1,002
Winsted	Litchfield County Hospital	48	2	50	603	22	625
Connecticut Hospitals Total:		6,543	616	7,159	70,352	11,053	81,405
Out of State Hospitals				28			147
Other Centers				33			296
Defense Department—Whole Blood				0			72
Defense Department—for Plasma				1,442			19,906
Total Distribution:				8,662			101,826
Converted to liquid and frozen plasma at Center				819			7,352
Unfit and Broken				16			232
Grand Total				9,497			109,410



last two years, was found to be in excellent condition and can still be used for emergency use.

When the Red Cross was designated as the collecting agency for blood for the armed forces during the war, collecting centers were established throughout the Nation. Our original collections were made throughout this State and up the Connecticut River valley into Massachusetts. Mobile unit operations were a part of the program in those days, but the main source of supply was a donor station of 14 beds in 3 stores which were leased opposite the Y.M.C.A. approximately at the site of the new Statler Hotel. During the three years of operation of this station, 100,000 pints of blood were collected annually, the largest daily collection being 475 pints on D-Day. With the cessation of hostilities the Red Cross ceased to collect blood in September 1945, but the original conception of a blood bank for civilian needs in Connecticut did not die.

The State Medical Society was approached and appointed an advisory committee to work with the leading citizens of the State with the idea of establishing a nonprofit organization to collect, process, store and distribute blood. This committee, however, was not successful in establishing such an enterprise. About this time the Legislatures of New York, Michigan, and Massachusetts had appropriated money for the establishment of blood banks for the citizens of their States. The State Department of Health in Connecticut was approached, reacted favorably, and introduced a bill before the General Assembly in 1947 to establish a blood bank. The Legislature was unwilling to appropriate the necessary funds, and that attempt failed. About this time the National Red Cross instituted what were and are still called permissive programs in which Red Cross chapters recruit donors for neighboring hospitals. One permissive program was established in this State in the Norwalk-Stamford-Greenwich area. This was helpful locally, although the small size of the bank prevented the ready availability of rare types of blood. In the meantime the American Red Cross had appointed a committee of physicians to survey the need for a nationwide blood collection program. Following their favorable report, the first regional blood center commenced operating in Rochester, New York in January 1948 with the approval of the American Medical Association, American Hospital Association, American Public Health Association and other interested agencies. Following this action of the American National Red Cross, negotiations were begun in Connecticut between the State Medical Society, the Hospital Association, and chapters of

the Red Cross in Connecticut, in particular the Hartford Chapter, to establish a Statewide banking program. It was agreed that Hartford should serve as the Center chapter. It was further agreed that two firm principles should govern policy. The first of these was that Red Cross would be sole recruiting agency in the State of Connecticut in order to eliminate all other competing recruitment. The second principle was that no payment would be made for the blood itself. Following prolonged and detailed discussion and planning, the first operation of the Connecticut Regional Blood Program took place in Danbury, Connecticut on June 5, 1950.

As the program enters its fifth year of operation, the question arises as to its future. The two stipulations previously referred to have been maintained. The blood needs of Connecticut hospitals have been provided for both through Mobile Unit operations and local Red Cross recruitment in times of general scarcity particularly of all types. This year the goal is the collection of 85,000 pints of blood for hospital use and the program has reverted to the original concept of meeting civilian needs which were started in June 1950, being changed almost immediately in August of the same year due to the Korean incident. At that time it became a combined civilian and defense operation. The future of the State program depends entirely upon the ability of the Red Cross chapters to induce the voluntary principles in recruitment of donors and to provide the necessary funds for this expensive undertaking. The past four years of success is a good omen for the future. The program should not be allowed to lapse, but should go forward with energy and vigor to maintain and surpass past achievements and continue the greatest humanitarian project ever launched in this State.

### President of Equitable Society Warns of Social Security Moves

The average American thinks of the Social Security plan as a low-cost program with little idea of what it is going to cost in the future directly and indirectly, accordingly it is important at this time when the whole program is under revision to encourage wide discussion of the old-age benefits under the system, Ray D. Murphy, president of Equitable Society, said before the National Industrial Conference Board annual meeting in New York. The cost of Social Security can have an important effect on the economy. Lord Beveridge, father of the British Social Security plan, was also a speaker on the "Welfare Concept."

## FAR-REACHING EFFECT OF COST

"The tax rate at present," said Mr. Murphy, "has risen to 4 per cent . . . 2 per cent from the employer and 2 per cent from the employee . . . and with no further increase in benefit level can readily rise eventually to be about 8 per cent—or even possibly 10 per cent. Necessarily, the top figure is uncertain since the result depends on many uncertainties. These uncertainties embrace employment conditions, wage levels, changes in longevity, changes in the proportion of the population at elderly ages, the incentives to the elderly to retire and so on. As taxes go up, as they will with no further increase in general benefit levels, will industry recoup by raising prices, will workers press for higher wages to maintain take-home pay? If they do, can we obtain such an increase in individual production as to maintain existing price levels? These are pertinent questions and grave questions. The fact that they exist should caution us to adhere closely to Lord Beveridge's injunction, which I quoted, that benefits should be confined to a subsistence level, and not attempt to include provision which can and should be made by private pension plans, individual savings and by relief measures for special cases of need which are more properly administered locally by municipalities and States.

## MISCONCEPTION ABOUT OASI

"A dangerous thing about Social Security in the United States," continued Mr. Murphy, "is that the American people have not yet come to fully realize that 'More can be given,' as Lord Beveridge said, 'only by taking more.' The nation simply does not get something for nothing in Social Security.

"Another fundamental misunderstanding among many of our people has been that Social Security taxes are a form of savings being stored up for the future and guaranteeing their future benefits. In 1936, when the plan was initiated, President Roosevelt said in a campaign speech: "'Here the employer contributes one dollar of premium for every dollar of premium contributed by the worker, but both dollars are held by the government solely for the benefit of the worker in his old age. In effect we have set up a savings account for the old age of the worker.'

"Use of the word 'insurance' is very objectionable to those in the insurance business. The words 'social insurance' slip easily from the tongues of many people, but the word 'insurance' suggests an individual equity relationship which simply does not exist in OASI. Neither is OASI based on commonly

accepted insurance principles.

"Moreover the incorrect impression that OASI taxes are insurance premiums or savings has doubtless misled many into thinking that the government has sufficient money stored up to meet the benefits becoming payable in the future from wage credits already acquired. The uninitiated, when told that the OASI holds some \$19 billion in government bonds may have such a belief strengthened. Little do they realize that some \$200 billion would be needed at the present time to cover the system's accrued liabilities.

"Essentially the OASI system is operating as a pay-as-you-go plan with a moderate contingency fund available to act as a buffer to cover any temporary excess of benefit payments over tax receipts—an excess such as might occur in a business recession. To put it another way, OASI is a system under which the active workers and their employers are contributing the taxes necessary to pay benefits to their fellow citizens on the benefit rolls. The active workers now covered under the system must look for their old-age benefits, not in any large measure to the Trust Fund, but mainly to the willingness of the next generation of active workers to pay the taxes out of which the retirement benefits will come."

## UN SOUND PROPOSALS IN BILL

Mr. Murphy cited some unsound proposals in HR7199 before Congress, chief of which is again to liberalize the OASI benefit formula particularly raising the tax base from \$3,600 to \$4,200.

"The new proposals would go clearly beyond the basic principle we must cling to," Mr. Murphy insisted, "and clearly invade the area in which private savings, insurance, and pension plans should operate. Such a shift would have far reaching effects. With no principle remaining to adhere to, very serious dangers would lie ahead.

"Another undesirable proposal in the pending bill would leave out of account, in determining benefit eligibility and the benefit amount, and periods in excess of six months in which the government adjudicates the individual to have been totally disabled. To start on the medical examinations and certifications necessary under this proposal is to open Pandora's box. Coming out of the box would be all sorts of complaints and pressures against adverse determinations. If there is one thing which insurance companies know, it is that determining disability is no simple problem of objective physical measurement."



## PROGRESS IN CLINICAL MEDICINE

### THE ROLE OF THE ANESTHESIOLOGIST IN GENERAL MEDICINE

NORMAN ZELDIS, M.D., *Hartford*

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The Author. *Anesthesiologist, Mt. Sinai Hospital,  
Hartford, Connecticut*

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THE anesthesiologist's position within the medical profession today is a well established one and deservedly so. Over the years his responsibilities have been greatly extended both inside and outside the operating room. Whereas, formerly his function was to provide mechanical pain relief to patients undergoing surgery, the modern surgeon has come to rely upon him preoperatively for evaluation of anesthetic risk and the choice of anesthetic agents; in the operating room for the skillful administration of various agents so as to disturb minimally the patient's physiologic processes and thus enhance the reestablishment of normal vital functions; and post-operatively for aid in the diagnosis, treatment, and prevention of the pulmonary and circulatory complications that may arise. In addition, a lesser portion of the anesthesiologist's time is occupied with diagnostic and therapeutic regional blocks; and in many hospitals he is also charged with the administration of intravenous and inhalation therapy.

These every day functions of the modern anesthesiologist are more or less familiar to the average practicing physician. What has not been widely enough popularized among physicians, however, is the role of the anesthesiologist outside the operating room. His skills and training can be of great assistance in the daily management of a variety of medical disorders. Unfortunately, too few internists and general practitioners avail themselves of the services of a qualified anesthesiologist. After a number of discussions with many practitioners, I was convinced that this paucity of anesthesiology consultation by medical men did not stem from unwillingness but from an unfamiliarity with the part which the anesthesiologist is equipped to play in certain medical conditions. It is for the purpose of clarifying for the medical practitioner just how and when the anesthesiologist can be of assistance that this paper has

been undertaken; and perhaps, in this way, to place due emphasis on a role of anesthesiology which is too often overlooked and, therefore, too infrequently utilized.

#### 1. THE COMATOSE PATIENT

A common condition which a medical practitioner is sooner or later called upon to see in his practice is coma. In any given case the etiology may be obvious or obscure. But whether it be due to alcoholism, trauma, a cerebrovascular accident, poisoning by drugs (barbiturates, opiates, carbon monoxide); or whether it be associated with diabetes, uremia, heat exhaustion or electrical shock, there are several life-saving measures which must be employed even before any definitive treatment or diagnostic procedures can be undertaken. The first, and most important, is to secure an adequate airway and to establish effective ventilation. By "ventilation" it is meant that the patient should not only be receiving a sufficient supply of oxygen but also ridding himself of excessively accumulated carbon dioxide. This cannot be overemphasized, since any considerable period of hypoxia or asphyxia in a comatose patient may prove disastrous.

It is sheer folly to think that all one need do is to place the unconscious patient in an oxygen tent or to insufflate nasal oxygen. To what avail is an environment saturated with oxygen when the airway is obstructed by mucus or by a tongue that has fallen into the posterior pharynx? And even after the nasopharynx has been thoroughly suctioned and an oropharyngeal airway properly placed, the patient's respirations may be so depressed that it is impossible to establish effective ventilation without passing an endotracheal tube and applying artificially controlled respiration. It is this point that I would like to drive home with full force to all medical practitioners, namely, that the establishment and maintenance of a patent airway and effective ventilation is the prerequisite of beneficial resuscitative measures in patients who are unconscious for any reason. This

becomes even more impressive when it is realized that a high percentage of patients suffering from alcoholic stupor, head injuries, cerebrovascular accidents, barbiturate poisoning, and diabetic coma die, not directly from the drug, injury, or disease, but from the asphyxia associated with an inadequate airway.<sup>1,2</sup>

Since an ineffective airway may often be the difference between life and death, then it becomes incumbent upon the practitioner of medicine to be able to detect the inadequate airway. In this regard, what has impressed me is that too much reliance is placed on the color of the patient. This alone is not a sufficient index of an obstructed airway, since skin color is apt to vary with the lighting in the room as well as with the experience of the individual observer. Moreover, the skin does not appear cyanotic until 5 Gm. per 100 cc. of the circulating venous blood is in the reduced form. It is the absolute amount of reduced hemoglobin, not the percentage, that makes one appear cyanotic; therefore, a markedly anemic individual could not possibly show cyanosis even when severely anoxic. Conversely, the polycythemic patient, whose hemoglobin content of the blood is considerably increased, appears to be cyanotic when only slight anoxemia is present.<sup>3</sup> One must also remember that when cyanosis does make its appearance, it is an indication of an advanced degree of anoxemia. The vigilant observer should be able to detect the anoxic state before the onset of frank cyanosis. In this regard, the behavior of the accessory muscles of respiration may indicate significant obstruction even when gross cyanosis is absent. Rather than depend on skin color alone, one should look for respiratory retraction at the neck or intercostal muscles, dissociation of diaphragmatic from intercostal movements, audible wheezes or rhonchi, stertorous breathing, and large quantities of mucus secretion in the oral pharynx.

The experienced anesthesiologist excels in the proper management of the airway in unconscious patients, since it is one of his chief concerns in the operating room day after day. It is in this area that he can be most useful to the practitioner in the treatment of coma. The practitioner would do well to consult with the anesthesiologist and encourage him to institute all measures which are necessary to securing an effective airway. If an endotracheal tube and artificial respiration are indicated, he can accomplish this, and the practitioner will be free to attend to the other aspects of the case. Should the anes-

thesiologist decide to leave the endotracheal tube in place for a day or more, he will assume the responsibility of keeping the tube well suctioned, of changing it every six to eight hours, and of removing it when the cough reflex returns.

Coma due to severe barbiturate poisoning deserves some special consideration at this time. Since it is one of the favorite methods of suicide in urban areas, very few practitioners are likely to escape the responsibility of attending a case. Whether accidental or intentional, barbiturate poisoning may be considered severe when any one or more of the following four conditions prevails: unconsciousness for 24 hours prior to hospital admission, absence of all reflexes, profound shock, or marked hypothermia.<sup>4</sup> In these extreme cases the attendance of a qualified anesthesiologist should be mandatory. There is no doubt that a good many people die of barbiturate intoxication, but it must be made clear that very few of those who arrive at the hospital alive will succumb if the most effective treatment is applied. The establishment and maintenance of an adequate airway is by far the most important consideration in the treatment from beginning to end, especially if the patient is cyanotic, with shallow breathing, has nonreactive pupils and a rapid, thready pulse. Recovery is impossible, no matter how good the treatment is in other respects, if sufficient oxygen is not introduced into the patient's lungs and if excessively accumulated carbon dioxide is not removed. More often than not, cessation of respiration is due to asphyxia rather than to the direct depressant action of the barbiturate drug. The anesthesiologist, armed with his laryngoscope, endotracheal tube and suction equipment, may often make the difference between life and death.

If it appears that the management of the airway has been overly stressed, justification can be found in the fact that, on too many occasions, undue emphasis has been placed on therapy with the so-called analeptic drugs such as picrotoxin, metrazol, caffeine, benzedrine and coramine. The greatest drawback of these drugs is the fact that they have assumed an unwarranted prominence in the treatment, and the physician has too frequently taken the position that there is little else he need do except apply the "antidote." Such an attitude may give him a false sense of security, since he is basing treatment on the ill founded conception that the "antidote" alone is life saving. These drugs are neither antidotes nor truly analeptic, since, by definition, an



analeptic agent is one which can reverse the action of a depressant drug either by chemical neutralization or cellular displacement.<sup>5</sup> None of the currently used drugs achieve this. They are merely stimulants which produce a physiologic antagonism, stimulating the same cells which are being depressed by the barbiturate. They usually accomplish their effects only in the presence of drug depression and then when given in subconvulsive doses. Such an effect can be hazardous, since it increases the need for cellular oxygen at a time when the vital tissues are already poorly oxygenated, thus actually imposing a greater strain on the patient. Furthermore, several of these drugs can induce convulsions when they are not used with the utmost care.<sup>6</sup> By their central stimulation they also produce altered signs which confuse the clinical picture so that the practitioner does not get a clear idea of how the course is progressing. Without these drugs, what the patient shows is either the result of hypoxia or the direct depression by the barbiturate, and the physician knows every minute how the patient is faring. Finally, by considerably increasing reflex activity with these drugs, an endotracheal airway might have to be removed prematurely lest laryngeal edema ensue.

The two greatest arguments favoring the use of the so-called analeptic drugs is that they improve the depth of respiration and the efficiency of the circulation. But those patients who need respiratory stimulation are already under the influence of the most powerful respiratory stimulus, namely, oxygen lack and carbon dioxide excess. As for improving the circulation, a much more effective drug is nor-epinephrine (Levophed), 4 mgm. of which can be added to a liter of intravenous solution and allowed to run as a continuous drip. Its powerful vasoconstricting effect may then be easily controlled by regulating the rate of flow to maintain a desired level of blood pressure. Moreover, this is achieved without producing the decreased renal blood flow that is seen with many of the other vasoconstricting agents. The action of nor-epinephrine is almost entirely peripheral with little or no central stimulating action so that the clinical picture does not become confused.

If the coma is due to overdosage with opiates rather than barbiturates, the anesthesiologist can again be of valuable assistance, since he is singularly qualified to treat respiratory depression from any cause. In addition to instituting the resuscitative

measures already discussed, he can also aid in administering the specific opiate antagonist, N-allylnormorphine (Nalline). This drug has successfully counteracted such respiratory depressant drugs as morphine, Demerol, Pantopan, Dilaudid, Methadon, Metopon and Dromoran,<sup>7</sup> but has not been consistently effective against the barbiturates. It is best administered by continuous infusion after an effective single dose has been given intravenously. The effect of Nalline is to increase the rate and depth of respiration, thereby reversing the severe respiratory acidosis that is present. However, it must be emphasized once again that the drug alone is not the all important factor and that the most effective—often lifesaving—therapy must be predicated on the early establishment and maintenance of a patent airway and adequate ventilation.

If the patient has been rendered comatose by carbon monoxide poisoning, the anesthesiologist may be called to administer a carbon dioxide-oxygen mixture, if this seems to be indicated, in an attempt to enhance the dissociation of carboxyhemoglobin. Here, as with all unconscious patients, the oxygen tent cannot supplant the experienced anesthesiologist. The oxygen tent alone does not guarantee that the patient is being sufficiently oxygenated unless the airway is clear and the respiratory minute volume is being adequately maintained. Moreover, oxygen tents interfere considerably with good nursing care.

## 2. INTRACTABLE PAIN<sup>8,9,10</sup>

Clinically, the most common method of managing intractable pain is by the administration of narcotics and/or sedatives which alter the perception of and modify the reaction to pain. This method is much simpler and less time consuming, especially when the busy practitioner is unable to discover the physiological or the pathological mechanism that is producing the pain. All of us, at one time or another, have resorted to the use of narcotics with varying degrees of failure and without due consideration of their undesirable side effects on the central nervous system, the respiratory, gastro-intestinal, and genitourinary systems. The use, or perhaps misuse, of these drugs has stemmed from the physician's frustrated feeling that he had little else to offer the patient who was a frequent visitor to his office in anxious search of a new cure for his intolerable pain. And even though we have been consciously aware of the possible problem of drug addiction, the temporary beneficial results obtained by one or another of a long

list of pain relieving agents have spurred us on in an honest effort to help the chronic pain sufferer. A good deal of this prescribing in willy-nilly fashion cannot be wholly blamed on the failure to treat conscientiously but, to a great extent, on the large void that exists in our fundamental knowledge of the complexities of the various pain mechanisms.

How, then, is the anesthesiologist able to help the practitioner with his cases of intractable pain? When the practitioner has exhausted every form of treatment without satisfactory relief, and before placing the patient on a prolonged opiate regime, why not consult the anesthesiologist for the possibility of an appropriate analgesic block? Perhaps that particular disorder will lend itself to analgesic blocking with surprising results. At least the anesthesiologist is in a better position to determine whether or not any given patient should receive a block. When executed properly, analgesic blocking usually does not add to the patient's discomfort, is not often followed by untoward reactions, and does not interfere with other forms of treatment. In some instances it not only relieves pain but may also arrest the whole process of certain disturbed physiological mechanisms and effect a return of normal function.

Among the severely painful medical conditions which the anesthesiologist has successfully treated with nerve blocks are acute torticollis, shoulder and other joint pain, postherpetic pain, trigeminal neuralgia, post-traumatic pain, reflex sympathetic dystrophies such as phantom limb and shoulder-hand syndrome; vasospastic conditions such as Buerger's disease, Raynaud's disease and thrombophlebitis; pain associated with neoplasia. Particularly in advanced neoplastic disorders can successfully executed blocks replace the massive narcotic therapy employed so frequently for pain relief. In such visceral disorders as chronic pancreatic disease and postcholecystectomy syndrome, beneficial results may often be obtained by interrupting their sympathetic nerve pathways with subarachnoid, epidural, or paravertebral blocks. If such a splanchnic block is effective, relief of pain may be dramatic and permanent after surgical splanchnicectomy.

From a diagnostic-prognostic viewpoint, analgesic blocking may be used to determine the pathways of the pain mechanism. In this way, visceral may often be distinguished from somatic pain, functional from organic pain. In this way, too, the patient may be given the chance to experience temporarily the

effects of interruption of a nerve pathway before it is made surgically permanent.

### 3. ECLAMPSIA<sup>11,12</sup>

There are several ways in which the anesthesiologist can be of aid to the practitioner of obstetrics in the treatment of the convulsive eclamptic and the severe pre-eclamptic. Since the underlying physiopathology appears to be one of generalized arteriolar spasm, the most effective treatment is that which is directed at relieving the vasospasm. This can be readily accomplished by continuous spinal analgesia with dilute anesthetic solutions such as 0.1 per cent pontocaine or 1 per cent Lucaine. By blocking the sympathetic pathways, vasodilatation occurs which results in a lowering of the hypertension that is present. The load carried by the heart is eased, pulmonary edema is relieved, oxygenation of the brain is increased and peripheral edema decreased. Of great importance is the fact that, when the level of analgesia is carried high enough, there is an increased output of urine and a decreased adrenalin output into the circulation. The relief of pain which follows a successful subarachnoid block also relieves nervous irritability and thereby makes for a more restful patient. In the patient with fulminating pre-eclampsia, a continuous spinal block will usually prevent convulsions and will obviate the need for the severely depressant sedative and narcotic drugs which are so often used to relieve pain and restlessness. If the patient is already in labor, or if so close to term that labor can be successfully induced, the block can be continued until delivery is effected. Or if cesarean section is decided upon, the operation can be carried out under the same analgesic block.

The convulsive eclamptic who becomes comatose presents, in many respects, the same problems as the patient under general anesthesia. Therefore the anesthesiologist is particularly qualified to aid in the management of this phase of eclampsia. The usual treatment of these patients has been heavy sedation with barbiturates and morphine along with the intravenous administration of magnesium sulfate. These usually control the convulsions and, to a lesser extent, the hypertension. But these drugs are not effective in maintaining an adequate urinary output. If anything, they interfere with the production of urine, since it has been shown that there is a diminished urinary secretion following the depression of blood pressure by barbiturates and opiates. Narcotics are, in general, antidiuretic. Evidently,



then, the selection of the type of sedation to be used in the treatment of toxemia assumes great importance. The anesthesiologist, because of his thorough knowledge of the pharmacologic action of depressant drugs, is singularly qualified to aid the practitioner of obstetrics in this important aspect of the management of eclampsia. In addition, his presence may be necessary to ensure adequate ventilation of the patient during and after a distressing convulsion.

#### 4. INFANT RESUSCITATION<sup>13,14</sup>

The central theme around which this paper has been contrived is that the anesthesiologist is an expert in the treatment of anoxia from any cause. This fact must be thoroughly recognized by all of his colleagues if he is to extend his functions successfully to the broader field of general medicine on a consultant basis. For who can be better qualified in this than one who, in his daily toils in the operating room, is constantly faced with the problems of hypoxia and anoxia with all their complex ramifications?

The fundamental physiopathologic change in asphyxia neonatorum is anoxia. Secondarily, there occurs a chemical upheaval in the fetal blood consisting of a decrease in the concentration of oxygen, an increased carbon dioxide tension, a noticeable increase in lactic acid formation, and a pH change toward the acid side. Treatment, then, must be aimed at correcting the anoxia and at overcoming the primary pathologic lesion, atelectasis. This cannot be accomplished by vigorous spanking, jack knifing the infant, sprinkling ether on the skin, hot and cold tubbing, or by any other shocking manipulation of the infant. To the anesthesiologist, infant resuscitation requires the same basic considerations as the resuscitation of any unconscious patient, namely, thorough aspiration of the pharynx and nares, establishment and maintenance of a patent airway, administration of oxygen along with artificial respiration via a positive pressure apparatus, and maintenance of warmth. Since the anoxic respiratory center may be stimulated by afferent impulses from the skin, subcutaneous tissue, and joints, gentle rubbing and passive movements of the extremities, after a patent airway has been established, may initiate respiration in the mild to moderately depressed newborn; but this stimulation must be gentle to be effective. The use of stimulating drugs can do more harm than good, and the administration of carbon dioxide in any concentration is flatly contraindicated.

In many hospitals the obstetrician or a delivery

room nurse is in charge of resuscitating the apneic newborn. If it is conceded that the anesthesiologist is expert in the management of asphyxia and apnea, then this procedure rightfully falls into his province, and it is he who should be in complete charge of all resuscitative procedures at the well organized modern hospital whether it be in the operating room, delivery room, emergency room or on the wards.

#### 5. SYSTEMIC TETANUS<sup>15,16</sup>

In the past, patients with severe systemic tetanus succumbed to a combination of hypoxia and exhaustion which resulted from an unmanageable airway and the tonic contractions of all the respiratory muscles including the diaphragm. However, with the recent advent of the curariform drugs, a method of combating these violent muscular spasms has been formulated. This, along with the more frequent use of early tracheotomy and a better appreciation of securing an effective airway, has placed the treatment of tetanus on a sound physiologic basis.

The longer acting curare drugs, such as d-tubocurarine and flaxedil, may be used in divided doses intermittently, or the short acting succinylcholine can be employed as an intravenous drip to check the spasms. The latter is preferred by many because of its controllability. It has been shown that 200-400 mgm. of succinylcholine diluted in 1000 cc. of 5 per cent glucose in water and given every 8 hours as a continuous drip at the rate of 25-50 mgm. per hour is usually sufficient to prevent tetanic muscular responses to stimuli at all times. With adequate curarization, all the necessary technical procedures involved in nursing care may be accomplished without precipitating violent spasms. Curarization, in abolishing the severely painful tetanic spasms, also curtails the need for the unphysiologic massive doses of opiate, barbiturate, and other central depressant drugs, and only the usual hypnotic dose need be utilized for the production of sleep and allaying apprehension. This successful method of the treatment of tetanus suggests that a similar regime may be useful in the control of other acute convulsive disorders that impair respiration. By this means, adequate time would be provided for the establishment of a diagnosis and the institution of specific therapy.

#### 6. IMMEDIATE POSTOPERATIVE CARE<sup>17</sup>

It does not seem logical that the unconscious patient, on being returned to his bed, should be abruptly deprived of the skills of the professional

team that was in charge of his care in the operating room, since the immediate postanesthesia, postoperative period is indeed a crucial one. It is during this time that the stage may be set for some of the more serious postsurgical complications.

Wherever the postoperative patient be located, whether on the ward or in the recovery room, he is entitled to the available skills of an experienced anesthesiologist, who should be encouraged by the surgical staff to leave such orders as concern oxygen therapy, parenteral fluids and blood, and medications for the control of pain. He should also be charged with conveying to the nursing personnel in contact with the patient clear and detailed instructions regarding his immediate postoperative condition and care.

Most postoperative patients who are under the care of competent attendants require little attention from the anesthesiologist. However, from time to time occasions arise when the anesthesiologist can render valuable assistance in controlling severe pain and emergence delirium immediately following surgery. The use of small doses of morphine (gr.  $\frac{1}{8}$ ) or Demerol (50 mgm.) intravenously, a route which seems to have been entirely abandoned by the surgeon, is rapid in its action and often effective where larger doses by the subcutaneous route seem to be ineffective. Too often the surgeon has routinely written the p.r.n. opiate order "for pain and restlessness." Too often, however, restlessness is a symptom of shock, respiratory obstruction, or some other hypoxic condition for which the depressant action of an opiate is flatly contraindicated. The administration of oxygen for this type of restlessness is much more beneficial to the patient. In this regard the anesthesiologist is best qualified to determine the underlying cause of restlessness or delirium occurring in the immediate postoperative period and to direct treatment before a nurse has administered the routine narcotic hypo. At times he may find it wiser to substitute intravenous alcohol or procaine for opiate drugs.

Certain circulatory and respiratory complications may occur in the immediate postoperative period which can best be treated by the anesthesiologist. These include the hypotensive state and the accumulation of respiratory tract secretions. Serious degrees of circulatory depression are seen when the loss of body fluids has not been adequately replaced during surgery. Deep ether narcosis, large doses of sodium

pentothal, and the existence of hypoxia during anesthesia may contribute to the development of shock by depressing smooth muscle tone in the peripheral arterioles and by interfering with homeostatic mechanisms. An alarming drop in blood pressure may occur following the termination of cyclopropane anesthesia (so-called cyclopropane "shock"). Finally, spinal analgesia and sudden changes in position of the anesthetized patient may produce reflex depression of the blood pressure. The anesthesiologist who has followed the course of the patient throughout operation is, it seems to me, best suited to diagnose the cause of these circulatory disturbances and to determine what corrective measures may be needed. His skill in performance of difficult venipuncture and his experience with various forms of supportive therapy are valuable assets in the management of postoperative hypotension.

Respiratory complications usually resolve themselves into the prevention and treatment of atelectasis. The anesthesiologist is always equipped to perform tracheobronchial aspiration to remove accumulated secretions blocking the pulmonary tree and to stimulate coughing in the seriously ill patient and the semimobile elderly patient when the danger of atelectasis is imminent. This procedure will often obviate the need for bronchoscopy. Again, by the proper control of pain and its splinting effect on the accessory muscles of respiration he may prevent the stagnation of secretions in the tracheobronchial tree.

Another important function of the anesthesiologist which is not often mentioned under postanesthesia care is his role of instructor. The members of a well organized department of anesthesiology should be actively engaged in teaching the nursing personnel, interns and residents who are in contact with surgical patients something about the principles of postanesthesia care. Appropriate discussions and demonstrations should include evaluation of the patient's general condition with emphasis on the early detection of hypoxia (obstructed airway, accumulation of secretions etc.), appearance of the cold, clammy skin of patients in shock, and accurate observation of the vital signs. They should be taught to differentiate the lightly anesthetized patient who can be readily aroused from the comatose one with absent protective reflexes. Principal points should be given them concerning the prevention of dislodging intravenous needles, the detection of infiltration of fluids into soft tissues, and precautions to be taken for proper identification of blood and maintaining



the sterility of intravenous fluids. They should be taught something about the general indications and the techniques of administration of inhalation therapy, the uses of compressed gases, and the precautions to be taken to prevent fires and explosions. Some instruction should also be given regarding the active change of the patient's position and movements of the lower extremities while confined to bed, early ambulation, deep breathing exercises, the technique of proper nasopharyngeal suction, the encouragement of coughing to expel pulmonary secretions, the detection of abnormal bleeding, and the recognition of impaired circulation in limbs immobilized in casts and splints. Such a teaching program, when conscientiously applied, goes a long way in providing optimal postanesthesia care for the surgical patient.

#### 7. ELECTROSHOCK THERAPY

Recently the anesthesiologist has been encouraged by the psychiatrist to assist him in the application of electroconvulsive therapy. At our hospital these treatments are carried out very successfully in the outpatient department. The subject is instructed to omit all oral alimentation commencing at midnight prior to the morning of the scheduled treatment. About twenty minutes before the shock is applied, he is premedicated intravenously with gr. 1/150 atropine. The anesthesiologist then injects a sleep dose of sodium pentothal intravenously, usually 250-300 mgm., followed by 30-40 mgm. of succinylcholine through the same needle, and the needle is withdrawn. Within thirty seconds generalized muscle fasciculations are noted followed by generalized muscular relaxation. During the 30-60 seconds after the removal of the needle, the patient is artificially ventilated with 100 per cent oxygen via a face mask and anesthesia machine. The mask is then removed, the bite block properly placed in the mouth, this being facilitated by the relaxation of the jaw muscles, and the shock applied by the psychiatrist in charge.

As soon as the convulsion has terminated, the bite block is removed and the patient again ventilated with 100 per cent oxygen, especial care being taken not to hyperventilate the patient, since hypocapnia will delay the recovery of spontaneous respiration. Because of the short duration of action of succinylcholine, apnea will rarely last more than 2-3 minutes. However, resuscitative equipment, including endotracheal tubes and their attachments, must be readily

available even though they may never be used. The entire treatment consumes no more than 10 minutes, and the patient is usually ready to be taken home after 60-90 minutes of observation by trained nursing personnel. This type of spirited cooperation between psychiatrists and anesthesiologists has resulted in greater benefit to the patient in that the incidence of fractures has been noticeably reduced.

The discourse herein presented exemplifies some of the many activities which the anesthesiologist can contribute to the broad field of medicine. By no means is he desirous of inviting the accusation that he is intruding beyond his specialty. With collaboration, rather than by intrusion, he can extend his functions outside the confines of the operating room suite and apply his specialized skills wherever they may be needed. By encouraging this kind of teamwork, the medical practitioner will be able to add to his therapeutic armamentarium the many new agents and methods which are at the disposal of the modern anesthesiologist who, in turn, will be in a position to do a better all around job than ever before.

What I have presented is, in the field of anesthesiology, basic knowledge which is widely discussed and frequently utilized.<sup>18</sup> My only hope is that I have so organized it that it can be easily and broadly disseminated among those practitioners who are not in frequent contact with the specialty of anesthesiology. To quote a famous physician of another age: "This bouquet of posies I have plucked for you from other men's gardens; mine is but the string that ties them together."

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### Meeting of Connecticut Committee on Foods, Drugs, Cosmetic and Devices; May 27, 1954

The member societies and institutions were represented at this meeting as follows:

Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Barnett Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

Regarding Dry-Tabs discussed at a previous meeting, a letter from E. T. Wakeman, M.D., of New Haven was read as follows:

"At a meeting of the Executive Committee of the Connecticut Chapter of the American Academy of Pediatrics I asked for an opinion on 'Dry-Tabs.'

"It was the unanimous opinion of the committee that such medication should not be given without the advice of a physician; that  $\frac{3}{4}$  grain of ephedrine sulphate might be detrimental to the health of children six years of age and over, and would cause sleeplessness and restlessness; that the treatment of enuresis must be individualized—ephedrine might work but it is not likely to get at the cause. Hence the committee expressed universal disapproval."

On motion of Dr. DeVita, seconded by Dr. Wedberg, it was voted that it be the opinion of the Committee that "Dry-Tabs" should not be sold without a prescription.

Consideration of Sweetreets was postponed to the next meeting.

It was brought out by Mr. Plank that the U. S. Food and Drug Administration had ruled that any product containing more than 5 per cent of methyl salicylate would be considered to be misbranded if its label did not bear suitable warnings.

Dr. Hart reported that there had been one case of paralysis after use of the Salk vaccine before the field trials started. It was suspected that the patient had mumps. Dr. Dwyer said he understood there had been a 14 per cent increase in paralysis cases.

### Connecticut NP Postgraduate Seminar

The new officers of the Connecticut Postgraduate Seminar in Psychiatry and Neurology are John J. Blasko, Connecticut Commissioner of Mental Health, president; Philip J. Moorad, vice-president; William F. Green, secretary; Arthur Ebbert, treasurer; Charles Russman, program director. The Seminar, which is under the sponsorship of the Joint Committee of State Mental Hospitals and the Department of Psychiatry, Yale University School of Medicine, consists of a series of lectures on neurology and psychiatry given once or twice a week over a seven month period. (See page 798.)

### C.I.A.I. Opens Central Office

The offices of the Medical Director, Sidney Shindell, M.D., LL.B. and Business Manager, Mr. Murton B. Bauer of the Commission on Chronically Ill, Aged and Infirm, moved into new quarters, July 6. In a building across the lawn from the hospital, administrative and business functions for all C.I.A.I. units in the State will be directed from this new location. The space for this executive work was made available by the Veterans Home and Hospital Commission and was remodeled by the C.I.A.I.



## THE HISTORIAN'S NOTE BOOK

### DEATHS IN BRISTOL, CONNECTICUT: 1801-1850

ARTHUR S. BRACKETT, M.D., *Riverside, Connecticut*

A good but simple man used to rise in our prayer meeting each week and always gave the same prayer: "Oh Lord, make us to remember Thy mercies!" In the same spirit it is well for us to know how much better off we are than our ancestors.

The accompanying table has been made possible by a record book kept by Tracy Peck, Esq., who lived in Bristol from 1785 to 1862. His life as described in Epaphroditus Peck's History of Bristol, Connecticut, was one more occupied with public service and responsibilities than with his vocation of farming. He was Assessor, Constable, Tax Collector, Selectman, Town Agent, Representative to the General Assembly, and State Senator from the Third District, Clerk of Probate, Judge of Probate for nearly fifteen years, and Town Clerk and Justice of the Peace for more than twenty-five years; and he was Clerk of the Congregational Church and Ecclesiastical Society of Bristol. He kept an accurate record of the names of those who died, their ages at death, and the dates on which they died. For a part of the time he also recorded the cause of death insofar as it was reported to him.

Taking the number of deaths recorded in these records and the recorded population figures (calculated for the years in which no actual census was taken), the death rate in Bristol has been calculated for each year, and shown in the accompanying table.

The highest death rate in Bristol during the twentieth century was 18 per 1,000 for the year 1918. That was the year of the terrible influenza epidemic during the first World War. Yet the death rates for thirteen of the twenty-five years from 1801 to 1825 were over 18, eight of those years were over 20, and in 1810 the death rate was 28. Between 1825 and 1850, ten years had death rates above 18, and in 1839 the rate was just under 27.

The causes of death when given, also afford an interesting comparison:

In 1793, a year with 15 deaths, only two causes were mentioned, "fit" and "old age, in the hundreth year of his age."

In 1794, with 20 deaths, causes mentioned were "canker rash"—1, "black canker"—1, "putric fever"—1, "cholic"—1, and "scalded"—1.

In 1795, with 19 deaths, there were "consumption"—3, "dropsy and consumption"—1, "breaking of an ulcer"—2, "ulcer"—1, "cholera morbus"—1, "inflammation"—1, "scarlet and putrid fever"—1, "whooping cough"—1, "fits"—1.

In 1796, with 14 deaths, "fits"—3, "pleurisy"—2, "measles"—2, "inflammation"—1, "cold"—1.

In 1797, "cold"—2, "billious fever"—1, "ulcer in head"—1, "drowned" (at 1 yr. 8 mo.)—1.

In 1798, with 19 deaths, "dysentery"—7, "consumption"—1, "pleurisy"—1, "inflammatory fever"—1, "worms"—1, "disease in head"—(the infant Gideon Roberts) 1, "peripneumonia"—1, "fit of palsy"—1, "mortification"—1. Six of the seven deaths from dysentery were the wife and six children of Noah Byington all of whom died on November 4, 5, 9, 10, and 20.

Let us summarize the recorded causes of death for the years 1800 to 1815 (after 1815 very few causes of death are given), remembering that the population of Bristol in 1800 was 1,362, in 1810 was 1,428 and in 1815 was about 1,395:

- 40 cases of "canker rash," "canker and rattles," and "rattles"—probably diphtheria
- 39 cases of typhus—probably typhoid
- 38 cases of consumption
- 27 cases of "spotted fever"—spinal meningitis
- 18 cases of "inflammation"
- 16 cases of "fevers," variously designated as "yellow"—4, "billious"—3, "nervous"—2, "putrid"—2, "nervous and putrid"—1, and just "fever"—4
- 14 cases of "fits" designated "palsy"—6, "apoplectic"—2, "paralytic"—2, "epileptic"—1, and just "fits"—5. The word "fit" is defined in the dictionary (Thorndike-Barnhart) as "a sudden attack of disease." It is so used in these records.
- 13 cases of "peripneumonia"
- 9 cases of dysentery
- 6 cases of "dropsy"

- 3 cases of "opium" (infants, probably dosed for colic or other excessive crying)
- 3 cases of "child bed"
- 3 cases of "mortification" (probably gangrene)
- 3 cases of "pleuresy"
- 2 cases of "influenza"
- 1 case of "sting of bee" (the writer knew nothing about allergy)
- 1 case "overlaid" (an infant, by nurse or mother).

Mr. Tracy Peck himself summarized his records for the fifty years 1800-1850:

"After careful examination of, and computation from my record and other documents in my possession, I find that there were during the fifty years commencing on the first day of January, 1801, and ending the thirty-first of December, 1850, fourteen hundred and fifty-nine deaths in the town of Bristol; that the average age of these persons is twenty-eight years, four months, nineteen days, twenty two hours, fourteen minutes, twenty three 883/1459 seconds; that two hundred and ninety nine of these persons died under the age of one year; that but five of them lived to the age of ninety years, viz. Mr. James Cole, who died September 16, 1803, aged 96. Mr. David Moore (colored) who died January 2, 1823 aged 95. Widow Anne Nichols who died December 31, 1818 aged 91. Widow Ruth Gridley who died August 1811 aged 91. Widow Rachel Gaylord who died October 31, 1828 aged 91.

"The average age of those persons who died during the first twenty five years, is twenty-eight years, eleven months, twelve days, fourteen hours, fifty five minutes, thirty four 526/611 seconds, and of those that died during the last twenty-five years, is twenty-seven years, eleven months, twenty three days, twenty one hours, eight minutes, twenty nine 23/53 seconds.

"And that the population of Bristol in 1800 was 1362; in 1810, 1428; in 1820, 1362; in 1830, 1707; in 1840, 2109; and in 1850, 2884.

"Certified By,  
"Tracy Peck"

It is evident throughout these records that tuberculosis ("consumption"), typhoid fever ("typhus"), and diphtheria ("canker rash") occurred very frequently. Contrast the present, in 1953 diphtheria and typhoid fever have been stamped out. Deaths from bacterial causes have been almost eliminated with the use of antibiotics and sulphonamides. Cases of consumption are much fewer and less fatal. The death rate is cut to a fraction of what it was and the expectancy for a healthy life has been multiplied.

"O God, teach us to number Thy mercies!"

BRISTOL DEATHS, POPULATION, AND DEATH RATE PER  
THOUSAND 1801 - 1850

YEAR	DEATHS <sup>1</sup>	POPULATION <sup>2</sup>	DEATH RATE
1801	16	1369	11.7
1802	11	1375	8.0
1803	29	1382	21.0
1804	26	1388	18.7
1805	18	1395	12.9
1806	25	1402	17.8
1807	20	1408	14.2
1808	33	1415	23.3
1809	35	1421	24.6
1810	40	1428	28.0
1811	28	1421	19.7
1812	17	1415	12.0
1813	21	1408	14.9
1814	20	1402	14.3
1815	27	1395	19.4
1816	29	1388	20.9
1817	21	1382	15.2
1818	29	1375	21.1
1819	29	1369	21.2
1820	21	1362	15.4
1821	29	1396	20.8
1822	15	1431	10.5
1823	29	1466	19.8
1824	16	1500	10.7
1825	34	1534	22.2
1826	27	1569	17.2
1827	15	1604	9.4
1828	30	1638	18.3
1829	28	1672	16.7
1830	32	1707	18.7
1831	42	1747	24.0
1832	34	1787	19.0
1833	14	1828	7.7
1834	28	1868	15.0
1835	44	1908	23.1
1836	33	1948	16.9
1837	38	1988	19.1
1838	28	2029	13.8
1839	55	2069	26.6
1840	28	2109	13.3
1841	38	2186	17.4
1842	26	2264	11.5
1843	29	2342	12.4
1844	46	2419	19.0
1845	45	2496	18.0
1846	35	2574	13.6
1847	44	2652	16.6
1848	49	2729	18.0
1849	50	2806	17.8
1850	51	2884	17.7

1. According to Tracy Peck's Record.

2. Intercensal figures are estimated population.

NOTE. I wish to acknowledge the valuable assistance of Mr. Joseph W. Clapis of the State of Connecticut, Department of Health, Division of Vital Statistics.



## Special Article

### THE COMMISSION ON THE CARE AND TREATMENT OF THE CHRONICALLY ILL, AGED AND INFIRM

#### Administrative Policies Governing Grants-in-Aid for Programs of Physical Medicine and Rehabilitation Within Hospitals Promulgated July 14, 1954

##### I. INTRODUCTION

The recent developments and advances in the specialty of Physical Medicine have made it possible through the application of special techniques and attitudes of rehabilitation to restore many chronically ill and disabled individuals to the point of self-care and often to the point of reemployability. Complete modern medical care should therefore include provision of these services in each case where they can be of benefit to the patient.

In recognition of the role that specialized physical medicine and rehabilitation services can play in the care of long-term illnesses most prevalent in the older age group, as well as in the care of patients of all ages who are likely to become or remain welfare recipients because of disabling long-term illness, the CIAI Commission was created by the Connecticut General Assembly in 1945.

The Commission has consistently believed that the State should not only operate facilities for the purpose of making physical medicine and rehabilitation services available, but should support and strengthen voluntary community efforts to provide these services.

The Commission recognizes the desire of community hospitals to provide all the services required by the patients they are called upon to serve, and to place in the hands of the community physicians all the facilities which make for optimal patient care. While it is recognized that to be effective, rehabilitation must begin early in the course of disabling illness, it is also recognized that the expense of space, equipment and specially trained personnel may be a deterrent to the provision of such services in many hospitals in the State.

The Commission has, therefore, promulgated the policies set forth below to aid hospitals in the development of physical medicine and rehabilitation programs.

##### II. ESSENTIALS OF A HOSPITAL PHYSICAL MEDICINE AND REHABILITATION PROGRAM

A. A hospital Physical Medicine and Rehabilitation program should function as a consultative service and treatment program available to all patients who can profit therefrom, regardless of their primary diagnosis. It is expected that patients will remain the responsibility of their personal physicians and that the program for therapy will be prescribed by a physiatrist in consultation with the patient's personal physician.

##### B. Therapists.

The physical therapists employed by the hospital must, of course, be licensed by the State of Connecticut. Although there is no licensure required for occupational therapists, speech therapists or recreational therapists, these persons should meet the qualifications necessary for registration with their respective national associations. It is understood that equipment necessary for these persons to practice their specialties will be provided.

##### C. Integration of Physical Medicine into Total Patient Planning.

In any rehabilitation program provision should be made for total planning for the patient, including the hospital social service department as well as a vocational counselor who may be made available throughout the State Department of Education's Bureau of Vocational Rehabilitation. Wherever possible there should be close cooperation between

voluntary protective workshops and the hospital rehabilitation program.

### III. RULES GUIDING THE GRANTING OF FUNDS TO HOSPITALS BY THE COMMISSION

#### A. Hospitals Eligible to Receive Grant-in-Aid Funds.

Grants-in-aid may be awarded to any state-aided or municipal hospitals which satisfy the requirements set by the CIAI Commission for the receipt of such funds.

#### B. Bases for Contracts.

Contracts will be executed between each specific hospital and the Commission, which shall provide that, in consideration of the funds granted by the Commission, the hospital will agree to expend such funds exclusively for the development of a program of physical medicine and rehabilitation. Funds may be granted for:

1. The institution of a physical medicine and rehabilitation program.
2. Expansion of an existing physical medicine and rehabilitation program.
3. Support of a physical medicine and rehabilitation program during its initial phases of development, to insure proper operation and a high quality of care.

#### C. Approval of Program Plans by the Commission.

The Commission does not desire to exercise administrative control over the operation of physical medicine and rehabilitation programs in the hospitals which receive its grant-in-aid funds. It will, however, in the interests of assuring proper use of funds appropriated to it for this purpose, require an initial description of each hospital's proposed program, containing details of all proposed expenditures. Insofar as possible, the Commission will make available staff persons on a consultative basis to aid hospitals in preparing their initial proposals and in developing their programs.

#### D. Items for which Expenditures from Grant-in-Aid Funds will be Permitted.

1. The following items may be paid for with funds granted by the Commission:
  - a. Specialized equipment required by personnel in order to carry out effective courses of treatment.
  - b. Full- or part-time services of physical therapists, occupational therapists, speech therapists, and/or recreational therapists.

(Note: Grant-in-Aid funds may not be used to contribute to the salary of any therapist whose total compensation exceeds the State salary for a similar position.)

- c. Full- or part-time services of physicians qualified as specialists in Physical Medicine, employed as consultants for staff cases. (Note: No payment can be made from grant funds to such physicians if they are receiving a fee from the patient for such consultation.)

- d. Structural changes of limited nature required to make existing space suitable for therapy.

- e. Consumable supplies used exclusively by the above personnel in courses of treatment.

#### 2. Restrictions on use of grant-in-aid funds:

- a. Grant-in-aid funds may not be expended for the purpose of supporting basic medical, nursing, or subprofessional services, or for clerical assistance incidental to the operation of a physical medicine and rehabilitation program.

- b. So long as a contract is in effect between a hospital and the Commission, the portion of cost of the physical medicine and rehabilitation services borne by grants from the Commission shall not be used in calculating the average cost of special services charged to the patients under treatment. The hospital may, however, charge its usual rates for special services for patients who are receiving physical medicine and rehabilitation services.

#### E. Amount of Grant-in-Aid for Each Hospital.

The amount of funds any one hospital may receive is dependent primarily on the amount of appropriations received by the CIAI Commission. Priorities will be given to requests in the following order:

1. Requests for institution of new programs.
2. Requests for expansion of existing programs.
3. Requests for support during developmental phases.

Within each group of requests for the above purpose, consideration will be given to the needs of a particular hospital in the following order of priority:

1. Specialized equipment.
2. Salaries for therapists.
3. Consultation fees for physiatrists.
4. Structural changes of limited nature.
5. Consumable supplies.

The Commission will attempt insofar as possible to make available to each hospital funds in the following amounts:



1. Requests for new programs or expansion.
  - a. Up to 75 per cent of the proposed amount to be expended for specialized equipment and structural changes, and/or
  - b. Up to 50 per cent of the proposed expenditure for new personnel.
2. Requests for further support during developmental phases:
  - a. Second year of grant: Up to 50 per cent of operating budget.
  - b. Third and fourth years of grant: Up to 33 per cent of operating budget.
  - c. Fifth year of grant: Up to 25 per cent of operating budget.

The above amounts, if necessary, will be adjusted depending on the appropriation made by the General Assembly and the number of hospitals requesting grants. Also, consideration may be given to modifying the above formula on the basis of such special conditions as may exist at a particular hospital at the time a contract is negotiated.

Funds received by a contracting hospital, such as foundation grants and the like, except funds which may be made available by other state agencies for the specific purpose of aiding rehabilitation efforts, may be used as "Hospital Funds" in "matching" grants from this Commission.

#### F. Reports to the Commission.

The Commission will require, as an obligation under each contract, that the hospital send to it quarterly reports on forms furnished by the Commission, containing the following information:

1. Data on both inpatients and outpatients treated, including:
  - a. Significant identifying information including age, sex, race and marital status.
  - b. Town of residence.
  - c. Diagnosis.
  - d. Number of treatments given in the Department of Physical Medicine and Rehabilitation and duration of course of therapy.
  - e. Results obtained from treatment.
  - f. Agency (if any) responsible for support of patient.
2. Itemization of expenditure of all funds granted under the contract then in effect, and of the hospital's contribution to the P. M. & R. Department.

#### G. Duration of Contracts.

Each contract entered into between the Commission and an eligible hospital will be for the period of one fiscal year of the Commission, and cannot carry any guarantee of any subsequent contracts. Consideration of further contracts will be given on the basis of the above outlined reports, and the appropriation of funds to the Commission by the General Assembly. While it is the purpose of the Commission to encourage insofar as possible the development of physical medicine and rehabilitation programs within hospitals throughout the State it is not proper or practical that a State agency such as the Commission should indefinitely subsidize such programs. The full responsibility for maintaining a program, once it has been firmly established, must rest with the community in which each hospital is located.

### Physicians For State Service

At the present time the three State Mental Hospitals at Middletown, Norwich and Fairfield are admitting patients at the rate of about 3,500 per year. Of this number more than 1,100 are over 60 years of age. A large proportion of the 9,200 patients presently in residence are over 65 years of age and have many medical and surgical problems.

Because of the shortage of trained psychiatric manpower an attempt will be made to recruit general practitioners and other medical specialists for fulltime positions at the three hospitals. These physicians will work under the supervision of a trained psychiatrist and should have some desire to become acquainted with medical and surgical problems in the chronic psychiatric patient. Inservice training will be provided for successful candidates for these positions. Physicians who are interested should write to the Commissioner of Mental Health, 65 Wethersfield Avenue, Hartford, Connecticut.

### Average Length of Stay in 33 Connecticut General Hospitals

6 MONTHS ENDED MARCH 31	PATIENT DAYS	DISCHARGES	AVERAGE LENGTH OF STAY
1951	925,684	110,854	8.4
1952	964,777	117,331	8.2
1953	966,856	123,795	7.8
1954	999,643	129,654	7.7

## NEWS FROM WASHINGTON

### Three More Medical Bills Reach White House

In addition to three medical bills recently signed by the President—Vocational Rehabilitation, Medical Tax Deductions, and Indian Hospitals—as we go to press three more medical bills have passed Congress and are awaiting presidential signature. One would permit shipping companies to pay overtime to U. S. Public Health Service quarantine officers for out-of-hours inspection of incoming vessels. The Senate committee which held hearing on the bill reported that under the present system of inspections only between 6 A. M. and 6 P. M. 41 per cent of the vessels arriving in New York are held up pending quarantine inspections. Another bill boosts from \$500 to \$700 annually the amount of federal aid to states for each veteran hospitalized in state institution. The third bill authorizes the President to designate October 11 to 16 as “National Nurse Week.”

### Vote on Reinsurance Bill

The vote by the House to recommit the President's reinsurance program bill showed all of Connecticut's members of Congress voting against recommitment except Thomas Dodd who did not vote. The vote for recommitment was 238 to 134. The AMA has vigorously opposed this bill. Representative Will Neal, Republican of West Virginia and one of six physician members of Congress during the debate said, “It is only establishing another agency from which we do not expect to get anything except a few more government jobs and a little more bureaucracy.”

### Past President of AMA on Government Committee

Edward J. McCormick who has recently retired as president of AMA has been selected to serve on a new committee of the Commission on Intergovernmental Relations to study U. S. public health grants. Serving on this same committee are two members of the Connecticut State Medical Society, Theodore Klumpp, president of Winthrop Chemical Company,

and Albert Snoke, director of Grace-New Haven Community Hospital.

### Appropriations Reduced

President Eisenhower signed Hill-Burton expansion program into law July 5. But funds slash imposed by House Appropriations Committee will hold it on the ground unless Senate shows more leniency. White House requested \$35 million for construction grants, \$2 million for survey grants and \$400,000 for operating expenses. HAC killed all but survey funds. Public Health Service had planned to apportion \$10 million each for chronic beds, diagnostic/treatment centers and rehabilitation facilities and \$5 million for convalescent homes. As bill now stands, it will have only \$2 million for distribution among states to survey their needs.

At the same time House Appropriations Committee approved \$44,025,000 for Federal Civil Defense Administration, of which \$25 million must go for purchase of medical supplies and equipment, Federally stockpiled. Total of \$10.5 million was allocated in matching funds to the states for purchase of various materials and services, about one-fourth of which would consist of medical items. FCDA asked for \$85 million and, as in past, its request was trimmed sharply.

Veterans Administration fared better than Hill-Burton and FCDA. It had requested \$3 million to supplement the \$598 million which it is getting in current fiscal year for inpatient hospital care. Full amount was granted, with the committee explaining that it will be used exclusively for hospitalization of nonservice connected cases.

### Senate Approves \$47 Million More for HEW Operations

The Senate has approved about \$47 million more for operations of the Department of Health, Education, and Welfare for the current fiscal year, which is in addition to the department's regular appropriation of \$1.6 billion. Largest single amount was \$35 million for the new Hill-Burton hospital construction program, to finance clinics, rehabilitation cen-



ters, chronic disease hospitals, and nursing homes. The House had approved only \$15.7 million for this purpose.

Conspicuously absent from the supplemental appropriations bill was \$325,000 Secretary Hobby had asked to start the administration's reinsurance plan, which was defeated in the House on July 13. The budget request was made subsequent to the House action, as an indication the administration had not given up hope of having the legislation enacted.

The administration's request for \$14 million to finance expansion of the social security program was cut to \$6 million by the Senate. Other items in the Senate approved appropriations bill included: \$6 million for the expanded vocational rehabilitation act, which was signed into law recently by the President; \$1.8 million to finance such civil defense activities as water and air testing as a protection against biological and atomic attack; and \$2.7 million for various educational and welfare programs.

### PHS Allocates 60 Per Cent of Current Year's Research Funds

Sixty per cent of the Public Health Service medical grant money appropriated to the National Institutes of Health for fiscal 1955 already has been allocated. Approximately one-third of the 1,442 research awards went to new projects and the remainder for continuing existing studies. The grants, totaling \$14,685,671, are for "basic and applied research in the major diseases afflicting Americans today."

Of the seven Institutes of Health, the National Cancer Institute distributed the largest number of new grants: 92, totaling \$981,074. Chemotherapy of leukemia and allied forms of cancer was listed as a typical subject of NCI research. The National Heart Institute has the largest number of continuation grants: 213, totaling \$2,283,370. Scientific investigations of NHI include effects of hormones on hardening of the arteries, edema mechanisms occurring in heart failure, synthesis of compounds acting on the heart, and effects of temperature and humidity on the circulatory system. A total of \$33,918,000 was appropriated for PHS medical research for the current fiscal year.

### Interns to be Checked on Military Planning

Some 2,500 medical interns will soon be hearing from Defense Department, which is seeking information

as to their plans for residency training and choice of military branch. In some respect this questionnaire survey will duplicate information collected last spring when these men were in last year of medical school but Pentagon wants to bring data up to date. Forms which they will receive must be returned no later than October 10. If not executed and sent back to Dr. Frank B. Berry, Assistant Secretary Defense (health and medical), it will be assumed that the doctor desires neither a commission in Reserve nor draft deferment for residency training.

If doctor-draft law is allowed to expire June 30, 1955, as expected, the only doctors liable for obligated military duty will be those previously deferred for medical education and/or internships. In order to receive consideration for residency training and be permitted to make a choice of military branch, registrants must fill out the Pentagon forms. Note: It is impossible to foretell how many will be deferred for residencies.

### Legislative Notes

The House Education and Labor Committee unanimously approved a bill permitting Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont to establish a New England Board of Education and pool their higher educational facilities for the use of the New England area; regional medical and dental schools would be one possibility. President Eisenhower has signed a bill permitting the setting of tolerances for certain pesticides used on food products. The legislation is now Public Law No. 518, 83rd Congress. A poll conducted by Rep. Ralph W. Gwinn (R-New York), whose district includes Yonkers, indicates that in his district: 84 per cent of the responding constituents oppose socialized medicine; 76 per cent disapprove of federal administration and control of universal health and medical services; 70 per cent favor non-profit voluntary health insurance; and 47 per cent approve of federal hospital construction.

### Presidential Executive Order

On August 2 amendment to executive order 10450 of April 27, 1953, adds illness (including mental) to the list of causes for removal from a federal job in the interests of national security. Heretofore "adjudication of insanity" was the test.

## New Legislation

**S.J.Res.181—Amendment to U. S. Constitution Relating to International Treaties.** (Bricker—R, Ohio, August 5.) Similar to an earlier version, this proposed amendment to the Constitution would require ratification by  $\frac{3}{4}$  of states within 7 years to become effective and would: (1) prohibit treaties made in conflict with the Constitution; (2) make a treaty ineffective as internal law in the U. S. without legislation valid without the treaty; and (3) require a yea and nay vote recorded by names for ratification.

Senator Bricker's S.J.Res.1 was defeated on February 26, 1954. A shift of one vote in the 60 to 31 lineup would have given the amendment the two-thirds majority required for a proposed constitutional change. The amendment was favored by the American Medical Association, by the American Bar Association and by other groups.

**HR8300—Internal Revenue Code of 1954.** (Reed, New York.) On July 28 the House adopted the conferee's final agreement on the omnibus tax bill. Of particular interest to medical profession: (1) Deductions for medical expenses permitted in excess of 3 per cent (currently 5 per cent) adjusted income; single person present maximum deduction \$1,250, new bill \$2,500; present over-all deduction \$2,500, new bill \$5,000; joint return present maximum deduction \$5,000, new bill \$10,000. Drugs not included in medical deduction, but cost of drugs in excess of 1 per cent of adjusted income could be deducted in addition to medical deduction. (2) Payments for loss of wages exempt up to \$100 a week; except first week, but if absence caused by injuries payments immediately exempt. Hospitalization for 1 day in the first 7 days of an illness would exempt from income tax all payments for loss of wages attributable to illness. (3) Medical expense deduction not allowed if reimbursement for medical care is tax exempt. (4) Employer-financed accident and health benefits fully exempt if they represent reimbursement for actual medical expenses (under current law, some employer-financed benefits not exempt) but such benefits taxable over \$100 if they are compensation for loss of wages under either an insured or noninsured plan.

## Senate Action

**S3447—Oral Narcotic Prescriptions.** (Long.) The Senate Finance Committee ordered this bill

favorably reported with technical amendments. It would amend the Internal Revenue Code to permit the filling of oral prescriptions for certain narcotic drugs "possessing relatively little or no addiction liability." This legislation has the approval of the American Medical Association, Commissioner Harry J. Anslinger, the National Association of Retail Druggists, and others. On August 9 the AMA suggested in a letter to Chairman Daniel Reed that the House Ways and Means Committee take similar action on a comparable bill (HR9163).

## U. S. To Finance Study Here For 100 Foreign Physicians

Foreign Operations Administration is preparing to spend \$480,500 to finance postgraduate study in the United States for 100 European physicians. Specialists will study for from six weeks to three months, while younger men will stay for a maximum of three years. Those to be invited will include all types of medical specialists, and much of the study will be designed to acquaint the foreign physicians with American hospital techniques. Selection will be made by local committees in the various foreign countries. The entire operation will be made by local committees in the various foreign countries. The entire operation will be directed by the American College of Surgeons, under contract to FOA.

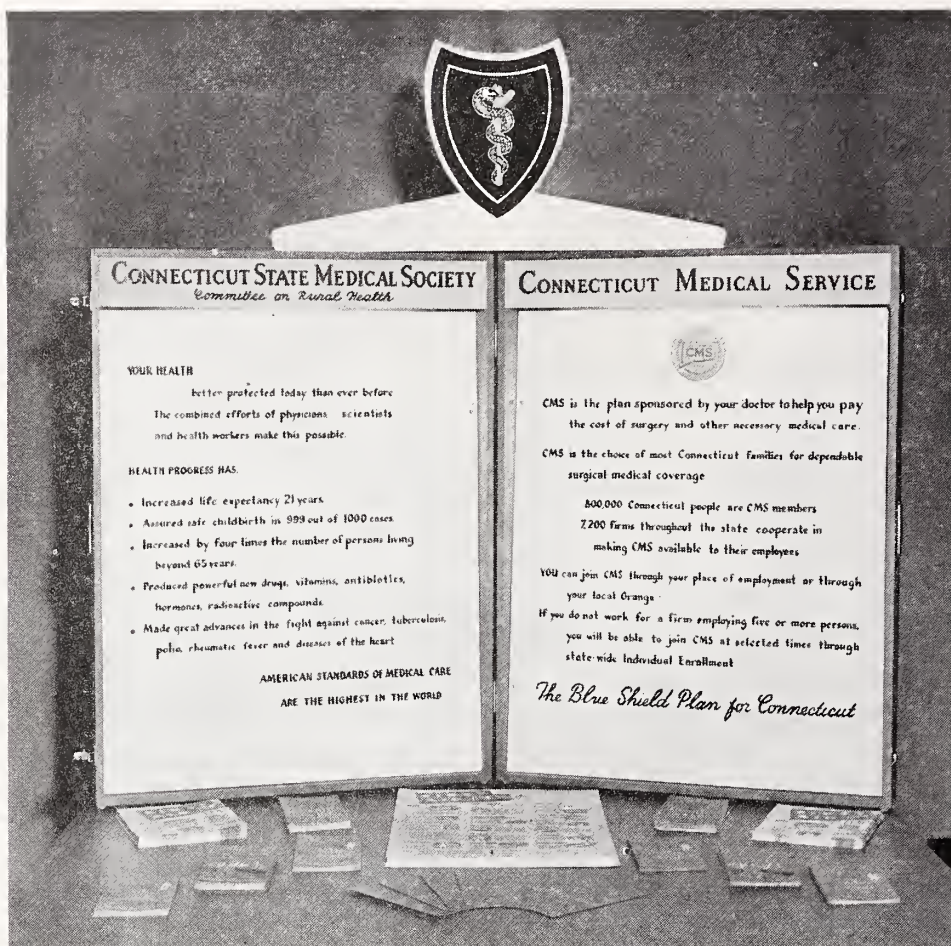
## Medical Ethics

Elmer Hess, president-elect of AMA, writing in *Missouri Medicine* quoted from the Principles of Medical Ethics and then added:

"These are the fundamental principles upon which the medical profession has developed and grown great and strong. There are no others. We have said nothing about money, fees, salaries, honorariums. We must care for the sick and infirm. Whether we receive a monetary reward or not is immaterial, but we can be assured that if we honestly are real practitioners of the Healing Art we will never starve. We have found out over many years of medical practice that the majority of our American people are honest and are desirous of paying a fair fee for a satisfactory service. The proof of this is the fact that the individual doctor is the most respected man in the community. He must live his ethics to warrant that respect. When a physician breaks that ethical code he is a traitor to his kind."



## TO HELP TELL THE STORY



### PROGRESS IN MEDICAL CARE

Several of these exhibits are being displayed at sixteen Connecticut fairs by local committees of the Woman's Auxiliary.

This project is now in its fourth year and is co-sponsored by the Society's Committee on Rural Health, the Committee on Public Relations and Connecticut Medical Service.

Informative leaflets concerning the progress of medicine and voluntary health plans are distributed as a feature of the exhibit.

#### *Remaining fairs at which the exhibit will be displayed:*

- September 4-6—Goshen Fair, Goshen
- September 4-6—Woodstock Fair, South Woodstock
- September 8-9—Wethersfield Grange Fair, Wethersfield
- September 9-12—North Haven Fair, North Haven
- September 11-12—Bethlehem Fair, Bethlehem
- September 17-18—Norwich Grange Fair, Norwich
- September 18-19—Terryville Country Fair, Terryville
- September 28-29—Union Agricultural Fair, Hazardville
- October 1-3—Berlin Fair, Berlin
- October 1-3—Stafford Fair, Stafford Springs
- October 9-10—Riverton Fair, Riverton

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## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

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### State and County Societies Participate in Television Series

The medical associations of New Haven, Hartford and Fairfield Counties are participating with the State Medical Society in four health education telecasts in the new series sponsored by the Connecticut TV Committee for Health Education.

Titled "Stay Well," the 13 week series was inaugurated September 12 from the television studios of WNHC-TV, New Haven. The programs are scheduled from 6:00 to 6:15 P. M. each Monday and will continue through October 4.

The first of the four medical association programs was telecast Monday, August 23, and the final program is scheduled for September 13. The following three programs will tell the story of modern hospital operation and are assigned by the TV committee to the Connecticut Hospital Association.

The committee producing the programs was formed in July, 1953 to provide television station managements and official and voluntary health agencies with a clearing house for authentic health information programs. Committee members comprise 21 representatives from 13 statewide health organizations and four television stations.

### Continued Demand for Documentary Film on Medical Care

The documentary film, "Your Doctor," produced by the American Medical Association and RKO-Radio Pictures, continues to be in demand by high school and industrial groups.

During the month of June, the film was screened in Connecticut before a high school audience in Washington, an employee group at the General Electric Company in Bridgeport, and students of the Center School, Beacon Falls, and the Boardman Trade School, New Haven.

A copy of the film is available at the office of the State Medical Society for physicians who may desire to use it as part of a speaking program. The film is

available for showing before community groups without charge other than that for return postage. Organizations using the film must provide their sound projector and other facilities.

### Hartford County Initiates Survey

A survey to determine the types of medical service available to residents of Hartford County was recently initiated by the Hartford County Medical Association.

The intraprofessional survey is part of a two-fold study that will also pinpoint public attitudes toward the profession. This latter part of the project is scheduled to get underway in October or November.

The survey directed to physicians is the first of its kind to be sponsored by the association. The survey questionnaire contains 13 questions, and subjects range from methods of handling night calls to time spent in giving free care at hospitals and clinics, office procedures and the type of service desired by physicians from their medical associations. Physicians need not sign the returns, but they are requested to indicate their age and the community in which they practice.

### Fairfield County to Sponsor Danbury Fair Exhibit

The Fairfield County Medical Association will sponsor a health education exhibit at the Danbury Fair, October 2 to 10, inclusive.

The Association's Public Relations Committee, under the chairmanship of Alfred J. Sette, Stamford, is in charge of the project and is currently arranging for teams of physicians to manage the exhibit. Members of the Woman's Auxiliary to the Association will assist in managing the exhibit during the hours of the Fair, 8:30 A. M. to 6:00 P. M. The exhibit to be displayed will be loaned by the American Medical Association and is titled "Organs of the Human Body."



## FROM OUR EXCHANGES

Black calls attention to two misconceptions that are commonly held by the medical profession. In his discussion of the topic "Do You Need to Know About Allergy" (*Ill. Med. Jour.*, 105:1), the first is that patients become sensitive to a large number of substances. Multiple sensitivity is, of course, the rule. But people do not become allergic to great numbers of food. As a matter of fact, patients are usually sensitive to a comparatively few things and the proper attention to these commonly produces satisfactory relief.

The other error is that skin tests are infallible indicators of the patient's sensitivity. There are no infallible reactions in medicine and skin tests are no exception to the rule. They can be helpful and can save a great deal of time in finding the offending substance but they are only a part of the allergist armamentarium. Skin tests must be accepted with discretion and must be correlated with the clinical history before they are pronounced the responsible agents.

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Carcinoma of the pharynx, larynx and cervical esophagus is a situation that confronts most doctors at some time in their career (Hilger et al., *Jour. Lancet*, 74:1). In the majority of laryngeal cases voice changes appear early in the disease. In hypopharyngeal and cervical esophageal cases symptoms are late in appearing and are usually localized discomfort and dysphagia. The prognosis for cure in these cases is exceptionally high when contrasted with malignant disease elsewhere. The cervical lymphatic barrier tends to localize the disease to the primary site and the regional glands. The five year cure rate declines rapidly with delay in diagnosis. Treatment, with few exceptions, is surgical. The loss of speech function is no longer an irreparable tragedy. The reconstruction of the pharynx and cervical esophagus through tubing of the cervical skin restores the swallowing function.

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Cordotomy in the high cervical region for intractable pain has been performed by French in 42 cases (*Jour. Lancet*, 73:7). He reports that the operation

made it possible to relieve pain in previously unrelieved group of patients. The operation has been effective in patients with malignant infiltration of the brachial plexus. It appears to be the most effective measure against phantom limb and tabetic pain. The high cervical operation has almost completely replaced dorsal root rhizotomy. Complications in the author's experience were less frequent than with thoracic cordotomy.

Less variation in the sensory levels were obtained with the high cervical operation than with the high thoracic. It is believed that the lateral spinothalamic tract is more consistent in its anatomical structure and position at the high cervical level.

The comment may be made that the operation sounds difficult and greatly subject to the judgment of the surgeon. It involves sectioning of the entire spinal cord tract conducting pain and temperature. Anything less than this spells a degree of failure in doing too much or too little at the time of operation. There were some complications such as urinary incontinence, motor weakness of an arm or leg, and postural hypotension. Apparently there were four deaths in the series of operations. Complete or partial relief of pain was experienced by all the patients who survived the operation. Apparently 32 of the series experienced complete relief of pain. As the object of the operation was the relief of pain, the procedure was evaluated on this single criterion.

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The clinician often wonders, what is the place of the plasma substitutes in his armamentarium? Soutter briefly offers a reply (*Jour. Amer. Geriatrics Soc.*, 1:8). Whole blood is the only adequate material for treating shock that is secondary to hemorrhage. Plasma and plasma substitutes are useful in restoring blood volume, arterial pressure and cardiac output until whole blood can be obtained. According to the author gelatin or Periston is a satisfactory substitute for this purpose. Dextran is less desirable because of its possible antigenicity and greater expense.

Serum albumen is dangerous in unskilled hands, and especially so in treating old people. Globulin is effective but is not yet available in sufficiently large volume for the treating of these cases.

None of the plasma substitutes is effective in treating hemophilia or for the transferring of immunological properties.

Blood bankers should remember that synthetic materials such as gelatin, Periston and dextran increase red cell sedimentation which may interfere with the reading of blood typing and crossmatchings carried out by microscopic techniques.

The author concludes that the plasma substitutes are in their infancy. When they are perfected they will probably be cheaper, more effective, less dangerous and more valuable to us all.

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Whipple emphasizes the importance of quizzing all patients about to receive an antibiotic as to their previous history covering the field of hypersensitive reactions (*Jour. Med. Assoc. Georgia*, 42:7). He cites a case of ulcerative cystitis and of ulcerative colitis following the injection of Procaine Penicillin. He points out that the indiscriminate use of antibiotics for trivial infections should be avoided because of the possibility of the development of sensitivity to the agent. It is important that patients should be carefully questioned as to previous doses of antibiotic, if any, and as to whether hypersensitive reactions occurred at that time.

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Wheatley in "A Formula for Child Safety" suggests the following activities for the physician (*Ohio State Med. Jour.*, 49:7):

- (1) Observe on home calls hazardous conditions around the house. Suggest corrective measures.
- (2) Give careful instructions when prescribing medicines to reduce the risk of over dosage or careless handling in the home. Eliminate sugar-coated pills which are temptation to young palates.
- (3) Study the causes of medical emergencies and accidents, particularly when the individual appears "accident susceptible."
- (4) Utilize accident case presentations in the hospital or medical society to emphasize ways to prevent accidents as well as how to treat them.
- (5) Help to develop community educational programs in cooperation with health departments and voluntary agencies.

The importance of this approach to preventive medicine is obvious if it is remembered that one-third of all the children who die, die of an accident.

Poisoning as represented by the misuse of household agents is a major problem of the practicing pediatrician.

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A guest editorial by Bartter in the *Virginia Medical Journal* is entitled "The Prevention of Kidney Stones: A Challenge to the Internist" (*Va. Med. Jour.*, 80:7). The passage of a kidney stone, so often ushered in by excruciating pain and not infrequently accompanied by bleeding, is usually an event of startling importance to its victim.

In general, stone formation requires three conditions in the urinary tract: the presence of poorly soluble material; insufficient quantities of water to keep this material in solution; and in most, perhaps in all cases, a nidus (cells, fibrin, bacteria) on which the stone may start. The last two conditions favor the formation of all types of stone. The forcing of fluids and the elimination of infection are obvious measures of prevention.

The search for the cause of calcium oxalate and calcium phosphate stones may lead the internist to abnormalities involving the patient's bones, his parathyroid glands, his kidneys, and his dietary and drug habits. Uric acid stones may be indicative of an elevated serum uric acid, which may in turn point to gout. Cystine stones are virtually always indicative of congenital cystinuria, a hereditary renal disease in which a number of amino acids are excreted in excess and cystine, being the least soluble, often forms calculi. The diagnosis of cystinuria can readily be made by testing the urine for cystine.

In summary Bartter points out that "the patient with a kidney stone presents to the internist both a valuable diagnostic clue and an unusual opportunity for preventive medicine."

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The August number of *California Medicine* is largely devoted to an interesting symposium on the outbreak of encephalitis in the Central Valley of California (79:2). Many authors contributed to the series of articles.

The outbreak of encephalitis included 348 laboratory confirmed cases of arthropod encephalitis. The clinical symptoms included fever, convulsions, headache, vomiting, drowsiness, irritability, restlessness, nuchal rigidity and tremor. The differential diagnosis on the basis of clinical observation was often difficult.



The cerebrospinal fluid is practically worthless in attempts to isolate the causal agent. In the usual case, diagnosis depended upon serological or immunologic tests (specific antibodies). In vitro complement fixation tests were considered a better diagnostic tool than the in vivo neutralization tests.

There were far more cases in California of Western equine than of St. Louis encephalitis. About one-third of the cases of Western equine encephalitis occurred in children under five years of age.

Emergency measures undertaken to control the epidemic were designed to supplement the normal control programs of mosquito abatement districts. There is needed a better understanding of the factors controlling survival of *Culex Tarsalis* over the winter months, together with better methods of measuring the prospects of a large number of infected vector mosquitoes early enough in the year to permit the establishment of preventive rather than palliative measures.

A continuing study of possible neurological sequelae or aberrations in behavior have been initiated. Changes in emotional and behavior patterns have been noted in some instances. In general, patients who recovered were apparently free of residual effects and have remained so.

Nothing is offered in this series of articles in the way of treatment of the acute phase of encephalitis.

\* \* \* \*

Injuries to the tarsus bones are, according to Diveley and Kiene, a frequent occurrence (*Missouri Med.*, 50:8). On the whole the condition is, in the author's opinion, poorly understood both as to the basic pathology and the type of treatment that should be instituted.

Diagnosis depends in a great measure on the use of x-ray. Not only should the usual anterior posterior x-ray be made, but the foot should be forced into inversion or eversion as the anterior posterior plate is taken. If the movement is painful it may be necessary to infiltrate the lateral ligament or medial ligament or both with 2 or 3 cc. of 1 per cent novocain. Every injury to the ankle should be x-rayed.

Displaced fractures of the talus should be accurately reduced. Simple undisplaced fractures of the calcaneus should be conservatively treated. Comminuted fractures of the calcaneus that extend into the subtalar or cuboid joints should be reduced, immobilized in plaster for a short time, and an early

subtalar or triple arthrodesis performed. With this procedure permanent disability will be minimized. Fractures and dislocations, or both, in the midtarsal region can be replaced generally by conservative manipulation but, if the joint surfaces are severely damaged, traumatic arthritis results and the involved joints should be subjected to arthrodesis.

### Polio Foundation Offers Fellowships

To increase the number of well trained teachers in the field of preventive medicine, the National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. This is a new effort to bring support to this field.

The program of study may be undertaken at an approved school of public health or in a department of preventive medicine of an approved medical school.

Fellowships will be awarded for one or more years, with stipends ranging from \$4,500 to \$7,000 a year, depending upon marital status and number of dependents.

The fellowships will be awarded only to graduate physicians in good health who are United States citizens or applicants for citizenship, have completed at least one year of internship in an approved hospital and have had not less than two years of additional training and experience, including some teaching responsibility, in one of the specialties related to preventive medicine. Candidates are selected on a competitive basis by the Clinical Fellowship Committee of the National Foundation for Infantile Paralysis.

Each recipient of a fellowship must have the intention of teaching preventive medicine in the United States or its territories after completing his studies.

Fellowship applications are accepted any time during the year, but are activated only after Committee action. Applications received by September 1 are considered about November 1; those received by December 1 are considered about February 1; and those received by March 1 are considered on or about May 1.

For further information address the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

## THE DOCTOR'S OFFICE

Richard B. Brown, M.D. announces the opening of an office for the practice of psychiatry at 85 Jefferson Street, Hartford.

Eugene H. Corley, M.D. announces the opening of an office for the practice of medicine at 439 East Main Street, Bridgeport.

Cleveland R. Denton, M.D. announces the opening of his office at 137 Jefferson Street, Hartford. Practice limited to dermatology and syphilology.

A. Arthur Fierberg, M.D. announces the opening of his office for the practice of internal medicine and allergy at 36 Woodland Street, Hartford.

Robert H. Green, M.D. announces the opening of an office for the practice of internal medicine at Boston Post Road, Madison.

Don A. Guinan, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 806 Main Street, Manchester.

Robert N. Hamburger, M.D. announces the opening of an office for the practice of pediatrics at 91 Cherry Street, Milford.

William E. Hill, Jr., M.D. announces the opening of an office for the practice of general medicine at 150 Meadow Street, Naugatuck.

Sidney Hurwitz, M.D. announces the opening of an office for the practice of pediatrics at 609 Savin Avenue, West Haven.

Walter P. Kosar, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 36 Woodland Street, Hartford.

Harold A. Lear, M.D. announces his return from military service and resumption of the practice of urology at 64 Garden Street, Hartford.

Robert J. Molloy, M.D. announces the opening of an office for the practice of medicine at 50 Farmington Avenue, Hartford.

J. E. Rosenfeld, M.D. announces the opening of his office at 70 Garden Street, Hartford. Practice limited to psychiatry.

Eugene Sillman, M.D. announces the opening of an office for the practice of internal medicine and diseases of the chest at 236 West Main Street, Meriden.

Carl Hendricks Wies, M.D. announces the association with him of Elsie M. Tytla, M.D. at 58 Hunting-

ton Street, New London. Dr. Tytla will limit her practice to the diseases of children.

## Opportunities for Journalistic Training

The Rensselaer Polytechnic Institute, Troy, N. Y., has only recently completed its second annual Technical Writers' Institute. Although this course, of five days' duration, ended on June 25, it is thought that some may be interested in obtaining information concerning next year's course. Some may be interested in rounding out a more complete writing field or may be occupied in fields particularly concerned with the courses offered.

This year the general subject matter was grouped under the following heads:

- The Language of Technical Writing
- Instructional and Operational Manuals
- Writing the Technical Report
- Letter Writing
- Human Relations in Communications
- Group Discussions in Various Writing Fields
- Adapting Technical Material
- Organizing a Writing Policy
- Tricks of the Trade.

Any one interested in obtaining more information about these annual Institutes should request additional information from Professor Jay R. Gould, director, at the Rensselaer Polytechnic Institute, Troy, New York. Application should be made as early as possible as the courses are limited to an enrollment of fifty.

The School of Journalism of the University of Missouri is preparing to introduce next year a program in medical editing and writing. The curriculum is being worked out, in cooperation with the new four year School of Medicine, to train students interested in scientific and technical writing of medical and pharmaceutical news and features.

At a recent meeting of the American Medical Writers' Association in Springfield, Illinois, such a proposed course was worked out with both the University of Missouri and the University of Illinois. These two schools have devised a program of study which is in keeping with the basic philosophy that approximately one-fourth of a journalism student's four year program should be devoted to professional journalism courses and three-fourths to academic courses. This curriculum includes courses in chemistry, biological science, bacteriology, and preventive medicine, and other scientific courses relating to medicine.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. Newell W. Giles, Darien

*President-Elect*, Mrs. Norman J. Barker, Collinsville

*First Vice-President*, Mrs. J. ALFRED WILSON, Meriden

*Second Vice-President*, Mrs. Frank L. Polito, Torrington

*Recording Secretary*, Mrs. Charles Culotta, Hamden

*Corresponding Secretary*, Mrs. C. Murray Gratz, Cos Cob

*Treasurer*, Mrs. Joseph Woodward, New London

Mrs. Vincent A. Gorman is the new State Publicity chairman. She remains chairman of Fairfield County's Publicity Committee.

### Nurse Recruitment

The Nurse Recruitment Committee, sponsored by the Greater Hartford Tuberculosis and Public Health Society, is pleased to announce the establishment of a Loan Fund which is available for use by graduate nurses. Money for this Fund was donated by the Hartford Foundation for Public Giving.

The amounts of single loans will be as follows: 1. a maximum of \$200 for summer study, to be repaid in the twelve months following the summer school session at the rate of approximately \$20 a month; 2. a maximum of \$450 for a full year of study, to be repaid in the eighteen months following the year's study at the rate of approximately \$25 a month; 3. smaller amounts may be borrowed for part-time study, and the repayment schedule will be worked out on an individual basis.

All loans are interest free. Repayment schedule adjustments will be considered by the Committee. There are no restrictions as to race, creed or color.

To be eligible for a loan, an applicant must meet the following requirements: 1. be a registered nurse; 2. be a resident of, or employed in the Greater Hartford area; 3. that the money be used for furthering her nursing education.

Application may be made by contacting the Greater Hartford Tuberculosis and Public Health Society, 65 Wethersfield Avenue, Hartford. Telephone CHapel 6-2555.

### The Bulletin

A change has been made in the date of the first issue of the national *Bulletin*. It will be September instead of August and will be ready for mailing early in September. National programs for the coming year, convention reports and addresses and articles of interest to the members of the Auxiliary will appear in it and subsequent issues. The *Bulletin* is issued four times a year: September, December, March and May, at a subscription price of one dollar. Subscriptions can be given to county or state *Bulletin* chairmen, or can be sent direct to the Central Office. All subscriptions, whether received direct from the subscriber or from a *Bulletin* chairman, will be credited to the State from which they are received. Subscribers are requested to send change of addresses promptly. Since the *Bulletin* is mailed under second class postage, there is no forwarding service.

### County News

#### FAIRFIELD

A fashion show to be held at Bloomingdale's in Stamford will be sponsored by the southern end of the county. It will benefit the Welfare Fund (Laurel Heights Sanitarium and the Nurse Scholarship Fund).

On October 9 the Annual Dinner Dance will be held at Fairfield Inn, Bridgeport. Proceeds will also go to the above causes.

Again in September there will be a Buffet Supper sponsored by present members and their husbands to welcome the new doctors and their wives into the community.

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## OBITUARY

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Louis F. Errico, M.D.

1892 - 1954



Dr. Louis F. Errico, member of the surgical staff of the Hospital of St. Raphael was born on October 27, 1892 in New Haven, Connecticut. He attended the local grammar schools, New Haven High School, and was graduated from the Yale Sheffield Scientific School in June 1918. He attended the Yale School of Medicine and graduated in June 1921.

Following graduation from medical school he interned at the Hospital of St. Raphael from June 1921 to July 1922. He served as assistant to Dr. Verdi from 1923 to 1925. Dr. Errico entered general practice in the City of New Haven, and was made an assistant attending surgeon on the surgical staff of the Hospital of St. Raphael in 1929. He was promoted to full attending surgeon in 1936. He was a member of The New Haven Medical Association, The New Haven County and State Medical Associations, The American Medical Association, and a Fellow of the International College of Surgeons. He served as a private in World War I.

Dr. Errico was a modest, unassuming, self effacing

man whose work at our institution was always characterized by his meticulousness and his affection for his fellowmen. He was always willing to help his fellow practitioners and was always loyal to this hospital. At no time did he ever refuse to take part in any of the activities of the St. Raphael staff. He was always courteous to the nursing staff and gave his utmost to the house staff in their training. In a word he was beloved by all.

The City of New Haven has lost a faithful practitioner and surgeon, the Medical Society a loyal member, and the Hospital of St. Raphael a diligent, hard working member of the surgical staff who gave his all to his institution of adoption. No one could expect more. We all grieve in his departure, but we yield to Divine Wisdom.

Joseph V. Petrelli, M.D.,  
Frank Mongillo, M.D.,  
Joseph D. Russo, M.D.

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### Million Dollars Contributed for Medical Education

More than a million dollars in contributions by American physicians during 1953 have been turned over to the National Fund for Medical Education to ease the financial plight of the nation's medical schools.

Dr. Edward L. Turner, Chicago, secretary-treasurer of the American Medical Education Foundation, presented a check for \$1,101,578.31 to the national fund. This includes a \$500,000 grant by the AMA Board of Trustees.

Since 1951 the AMEF has received \$3,563,883.09 as gifts from doctors to support the medical schools. The AMA Board of Trustees has made grants of \$2,000,000 of this sum.

It has been estimated that approximately \$10,000,000 is needed annually in addition to normal budgets to provide proper medical instruction in the nation's 79 medical schools.



1954-1955

*Scholarships for Medical Students*

The Connecticut State Medical Society offers a number of scholarships of Five Hundred Dollars each to students who are in their final year in an approved medical School in the United States or Canada and whose homes are in the State of Connecticut.

Information concerning these scholarships and application forms, which must be submitted before November 15, 1954, may be obtained from

Creighton Barker, M.D.

*Executive Secretary*

Connecticut State Medical Society

160 St. Ronan Street, New Haven, Conn.

# Dramamine's® Effect in Vertigo

*Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.*

Vertigo, according to Swartout, is primarily due\* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"\* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



*The site of Dramamine's action is probably in the labyrinthine structure.*

\*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.



## SPECIAL NOTICES

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

September 2

"Clinicopathological Conference"

Paul M. Sherwood, M.D.

September 9

"Errors in the Diagnosis and Management of Cancer"

Gershon B. Silver, M.D., chief of medicine, Veterans Hospital, Rocky Hill

September 16

"Clinicopathological Conference"

Paul M. Sherwood, M.D.

September 23

"Management of Pancreatic Lesions"

Charles Polivy, M.D.

September 30

"X-ray Conference"

Harold Schwartz, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room. All interested physicians are cordially invited to attend.

### NINETEENTH ANNUAL CONGRESS

United States and Canadian Sections, International College of Surgeons, Palmer House, Chicago, Illinois, Tuesday, Wednesday, Thursday and Friday, September 7, 8, 9, 10, 1954.

### AMERICAN MEDICAL WRITERS' ASSOCIATION 11th Annual Meeting

Hotel Sherman, Chicago, Illinois, Friday, September 24, 1954, C.D.T., Morning, Afternoon and Evening Program.

"America's only Association devoted to improvement of the written word of medicine."

This meeting will be held during the 19th Annual Meeting, Mississippi Valley Medical Society, Hotel Sherman, Chicago, Illinois, September 22, 23, 24, 1954.

Over 40 speakers. Over 40 scientific and technical exhibits.

The New Hotel Sherman, with 1600 modern rooms and the only Chicago loop hotel with drive-in garage service, can accommodate all attending the meeting if reservations are made in advance.

### 40th ANNUAL CLINICAL CONGRESS

American College of Surgeons

November 15-19, 1954, Atlantic City, New Jersey

### CONNECTICUT POSTGRADUATE SEMINAR IN PSYCHIATRY AND NEUROLOGY, INC.

The Eighth Connecticut Postgraduate Seminar in Psychiatry and Neurology will begin its courses of lectures on September 27, 1954 and will continue through May 9, 1955.

From September 27 through December 10, 1954, sessions in clinical neurology, neuroentgenology, electroencephalography, neuroanatomy, neurophysiology, neuropathology, and review and demonstrations in neuroanatomy and neuropathology will be held on Mondays and Wednesdays from 3:00 to 9:00 P. M. at Yale University School of Medicine, New Haven.

From January 3 through February 28, 1955 (Mondays) from 3:00 to 10:00 P. M. sessions in general psychiatry (psychopathology, clinical psychology, psychiatric syndromes, therapy, psychosomatic medicine, geriatric psychiatry and psychiatry and law) will be held at the Connecticut State Hospital, Middletown.

March 7 through April 11 (Mondays) a course in child psychiatry will be given, and April 11 through May 9, 1955 (Mondays) there will be a course in pediatric neurology, at Yale University School of Medicine, New Haven, from 6:30 to 9:30 P. M.

There are no fees for the above courses.

Copies of the program may be obtained from the Office of the Assistant Dean for Postgraduate Medical Education, Yale University School of Medicine, 333 Cedar Street, New Haven, Connecticut.

### HARTFORD MEDICAL SOCIETY PROGRAM

October 4—5:00-8:30 P. M.

Ovid O. Meyer, M.D.

"Some Aspects of the Anemias"

October 18—5:00-8:30 P. M.

John Parks, M.D.

"Lesions of the Vulva"

November 1—5:00-8:30 P. M.

Homer W. Smith, Ph.D.

"Renal Function"

November 15—5:00-8:30 P. M.

Harry Gold, M.D.

"Cardiac Arrhythmias: Mechanisms and Method of Treatment"

December 6—5:00-8:30 P. M.

T. Dunckett Jones, M.D.

"Rheumatic Fever"

December 20—5:00-8:30 P. M.

Alfred Gellhorn, M.D.

"Chemotherapy of Cancer"

1955

January 3—(Annual Meeting)

Samuel Ramsay, Esq.

"The Value of a Sense of Humor"

January 17—5:00-8:30 P. M.

Charles Lee Buxton

"Common Endocrine Problems in Gynecology"

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## NEWS

### *from County Associations*

#### Fairfield

William Kaufman of Bridgeport has been touring Europe—England, Switzerland, Denmark and Holland. In August he attended the World Mental Health Congress at Toronto, Canada.

The semi-annual meeting of the Fairfield County Medical Association will be held at the Ridgewood Country Club in Danbury on October 6. Golf will occupy the morning and early afternoon hours with the business meeting of the association at 4:30 P. M. A cocktail hour will be held at 6:00 P. M. Dinner will be at seven o'clock. The speaker at the dinner will be Rex Stout, noted mystery writer. He will speak on mystery writing and the role of the physician in mystery writing. Nathaniel B. Selleck, vice-president of the Association, will be the toast master.

#### Hartford

Close to 200 requests from radio listeners for Let Your Doctor Be Your Guide have been filled by HCMA since March. Burdette J. Buck, chairman of the Public Relations Committee, announced this month. Radio Stations WTIC, WDRC, and WCCC, WGTH have carried spot announcements over the air, prepared by the Public Relations Committee, on what the booklet is and how to get it. Spot announcements have called attention to Hartford County Medical Association's emergency service, its referral service and how to rely on your family physician. Other announcements urge the patient to discuss fees with the doctor, how often to be examined and the areas of the body covered in a physical examination. The booklet, a four page, red, white and black publication was designed last spring as a community service project. A typical spot announcements runs this way: "The Hartford County Medical Association advises you to discuss fees with your

## OUR NEIGHBORS

### Massachusetts

Dr. John F. Conlin, for the past several years the very efficient Director of Public Relations for the Massachusetts Medical Society, has resigned that position and accepted that of superintendent of Boston City Hospital. From all the reports in the press Dr. Conlin has a man sized job on his hands. There has been plenty of scandal regarding the management of the Pediatric Department at the hospital, and in addition graft, lack of proper facilities for the care of patients, and general mismanagement have been criticized by many. The teaching program of one of the medical schools in Boston is said to have reached a new low in the hospital. All these and other prob-

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physician. He'll welcome the opportunity. You can learn about this and how often you should see your family physician from Hartford County Medical Association's new free pamphlet called, "Let Your Doctor Be Your Guide."

Hartford County Medical Association's semi-annual meeting this year will be held in Manchester on Tuesday, October 26.

Two County hospitals were in the news this month when Bristol Hospital was approved by the AMA as a center for teaching interns, and New Britain General Memorial Hospital had its preliminary application for \$200,000 of federal money for construction approved. Incidentally, Bristol Hospital is now raising a \$600,000 building fund. New Britain Memorial's proposed building fund is \$2,395,000.

The American Board of Obstetrics and Gynecology has certified Henry M. Kaplan of New Britain. A graduate of New York Medical College, Dr. Kaplan entered private practice in 1951 and is now a junior attending obstetrician and gynecologist on the staff of the New Britain General Hospital.

New president of the Connecticut Diabetes Association is Samuel Donner of Hartford. Other HCMA physicians who are members of the Diabetes Association Council are: Burdette J. Buck, Marvin B. Day of Hartford, Sidney E. Eisenberg of New Britain and Howard J. Lockward of Manchester.

Donald A. Bristoll of New Britain was reelected president of New Britain Branch of the American Cancer Society this month. Henry Young was re-named medical advisor to this group. William Livingstone and Francis Buccheri were elected to the Board of Trustees.

Accolades were given to the New Britain Medical Society by the Common Council of the City of New

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Britain for its participation in a recent chest x-ray survey.

New members applying for membership in Hartford County Medical Association this fall are: Drs. John W. Bengston of Rocky Hill, Roger Garrett Conant and Joseph C. Cullina of West Hartford and Edmund Francis Ziegler of New Britain.

John Donnelly, clinical director at the Institute of Living, Hartford, is the author of "Psychiatry and



Its Role In Industry" published in *Connecticut Industry*, June 1954.

Wilmar M. Allen, recently director of the Hartford Hospital and now its consultant, has been asked to serve for nine months as Hospital Consultant to Belgium under the Fullbright Foundation. This is believed to be the first appointment under the Foundation. Dr. Allen will assume his new post in October.

Eleanor T. Calverley will spend the year beginning in September 1954 in Cairo, Egypt in order to accompany her husband, Edwin E. Calverley, PH.D. while he is acting as visiting professor at the American University at Cairo.

Arnold H. Becker of Bristol is author of "Treatment of Favism with Cortisone" published in *J. A. M. A.*, July 24, 1954.

### Middlesex

The intern staff at Middlesex Memorial Hospital this year is composed of four men: Merwin R. Dieckmann and Earl S. Patterson are both graduates of the medical school at the University of Iowa; Troels Grymer-Sorensen and Lawrence Strathman both have stayed on for a second year.

Irwin Israel, who was on last year's intern staff, is now in general practice in Colchester.

Eric and Bodil Langeback, the other members of last year's house staff, have returned to Denmark.

In July Edgar C. Yerbury completed ten years as superintendent at the Connecticut State Hospital.

Herman Strongin resigned as Middletown's Director of Health. John J. Korab is acting in this capacity until a successor is chosen.

Arthur V. McDowell, a Middletown native, opened his office in Cromwell. He is doing general practice.

### New Haven

David M. Little, Jr. of New Haven is the author of "Fetal Salvage in Cesarean Section—The Pediatric Viewpoint" published in *Bulletin of Maternal Welfare*, July-August 1954.

Girard F. Nardone, M.D. has been appointed to the Active Staff of the Griffin Hospital, Derby as an attending surgeon. Dr. Nardone is a native of Westerly, Rhode Island, and graduated from the University of Boston Medical School in 1944. He interned for one year at St. Francis Hospital, Hartford, and

from October 1946 through October 1950 trained in surgery as a resident at the Grace-New Haven Community Hospital. Since 1946 Dr. Nardone has served twice in the United States Navy and was released from active duty in May, 1954. He is a Diplomate of the American Board of Surgery, having successfully passed the requirements of that Board in 1953.

## NEW BOOKS IN REVIEW

*CHILDREN FOR THE CHILDLESS.* Edited by Morris Fishbein, M.D. New York: Doubleday & Co. 1954. 211 pp. \$2.95.

Reviewed by W. LESLIE SMITH

This is a rather small book composed of eight interesting chapters written by nine authors, each a recognized authority in his field. It is opened with a preface by Dr. Morris Fishbein. The table of contents, in addition to labeling the titles of the chapters and their authors, also breaks down each chapter into various subheadings for quick and easy reference.

The purpose of the book is to present a concise explanation of the medical, scientific, and legal facts about conception, fertility, sterility, and adoption. This it does very ably. In so doing it represents an excellent text and reference book to be prescribed by the physician for the infertile couple.

The opening chapter is entitled "On Being a Parent Today" by Sidonie Matsner Gruenberg, former director of the Child Study Association of America. The first half of the chapter deals with revolutionary changes and social trends in our family life of today, while the latter half deals with the more important and interesting facets of child guidance.

One chapter, by Dr. Edward Weiss, is devoted to the psychosomatic aspects of fertility and sterility. Another, by Dr. I. D. Rubin, gives a thorough but simple explanation of the causes of infertility and the type of investigation which the couple might expect. Dr. Nicholson J. Eastman devotes one chapter entitled "Human Fertility" to a social study of populations and their causes and effects; while interesting, it did not seem particularly germane. A chapter on "Artificial Insemination" by Dr. J. P. Greenhill goes into the matter of differentiating between husband and donor insemination and the important legal questions which may be raised in the latter. Another chapter, by Dr. Fred B. Kyger and Dr. Richard L. Jenkins, takes up the subject of adoption from all angles with important hints for the adopting couple as well as a warning in regard to legal entanglements.

The final chapter entitled "What Will Our Child Be Like?" by Dr. Benjamin C. Gruenberg, the author of "Biology and Man" traces the hereditary factors and their possible variations which will decide the outcome of a particular mating. This is quite interesting but somewhat

over the head of the average lay person unless rather well grounded in college biology.

The theme of the book as a whole goes much further than the average book of this type in that it stresses the responsibilities of the parents toward the anticipated child and most aptly defines the qualities necessary for parenthood. These are quoted by the Drs. Kyger and Jenkins in their chapter on adoption as "qualities of interest in children, capacity to understand children, the capacity for warmth without too much indulgence, the capacity to protect without smothering and to guide without dominating."

*FIFTY YEARS OF MEDICINE.* By Lord Horder, G.C.V.O., M.D., F.R.C.P. New York: Philosophical Library, Inc. 1954. 70 pp. \$2.50.

Reviewed by STANLEY B. WELD

Anyone who was fortunate enough to hear Lord Horder when he was in the United States explaining the plight of the British doctor and the workings of the National Health Service needs no introduction to this dynamic personality. Lord Horder has had a vital part in so many worthwhile movements in England it has been said of him that he has guided the care of the British citizen from birth to death. Chairman of the Fellowship for Freedom in Medicine, first president of the British Association of Physical Medicine, chairman of the Empire Rheumatism Council and Physical Medicine, chairman of the first Nursing Reconstruction Committee of the Royal College of Nursing, active in the Cremation Society, chairman of the Noise Abatement League, president of the Eugenics Society—all these activities and many more bear testimony to his valuable leadership during England's critical years.

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This volume is an expanded version of the three Harben lectures delivered by the author in December, 1952 at the Royal Institute of Public Health and Hygiene. In the first chapter, "The Birth of Scientific Medicine," Lord Horder reviews the development of chemotherapy, the birth of clinical pathology, advances in surgery, the introduction of the electrocardiograph, the electron microscope, radioactive isotopes, and the development of blood transfusion, the growth in endocrinology, and the confused development of social and of psychosomatic medicine.

In the second chapter, "Medicine Enlarges Its Boundaries," the author points out the importance now recognized of proper nutrition, of physical medicine and rehabilitation, of industrial medicine, and of nursing.

In the final chapter, "The Present and the Future," attention is called to the disappearance of certain diseases such as chlorosis and the development of new ones in their places. Among the latter he would include senility. There is an interesting discussion in this chapter on the National Health Service and its many blunders. Eugenics, cremation, noise abatement, all are briefly discussed, as well as personal experiences with some of the problems resulting from World War II. Lord Horder closes this chapter with some pertinent speculation about man's future and its relation to disease.

We are indeed fortunate in having in print these autobiographical sketches of this great man, portraying as they do phases of life in which he has played a prominent part. His style is interesting, his anecdotes entertaining, and his philosophy inspiring.

**MEDICINE AND SCIENCE: LECTURES TO THE LAITY NO. XVI.** The New York Academy of Medicine, Iago Goldston, M.D., Editor. *New York: International Universities Press, Inc.* 1954. 159 pp. \$3.

Reviewed by STANLEY B. WELD

The editor of this volume has collected six lectures intended for the laity but within the field of interest for the physician. The contributors are all men at the forefront of research: Norbert Wiener, Hans Selye, David M. Levy, Harold G. Wolff, Paul R. Burkholder and Mr. John E. McKeen.

The most interesting of the six chapters perhaps is the one by Dr. Burkholder on "Quest For Antibiotics" in which he outlines the discovery and development of the antibiotics thus far available. "Miracles—Mass Produced" by Mr. McKeen of Charles Pfizer and Company might well be read at the same time as it describes the development of the antibiotic pharmaceutical industry.

Dr. Wolff contributes a very lucid and instructive chapter on "Stress Emotions and Bodily Disease" in which he shows how different individuals react in times of stress.

The chapter on "Men, Machines, and the World About" by Norbert Wiener, P.H.D., is an interesting discussion of cybernetics. Then there is a short chapter by Dr. Selye on "The Renaissance in Endocrinology" and a very instructive chapter on "The Relation of Animal Psychology to Psychiatry" by Dr. Levy, professor of clinical psychiatry at Yale.

There is enough variety in these six chapters to interest laymen, physicians, public health workers, social workers and the scientific investigator.

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Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."<sup>2</sup>

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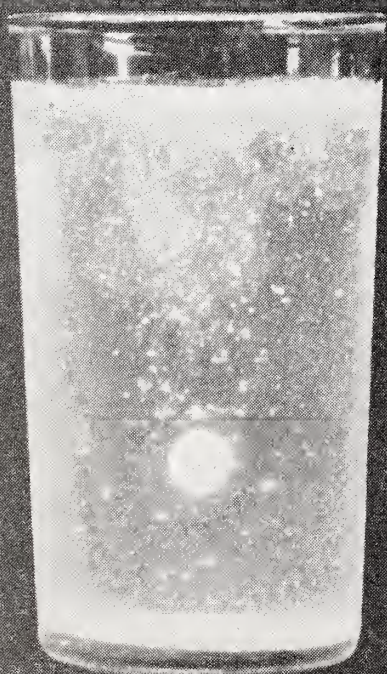
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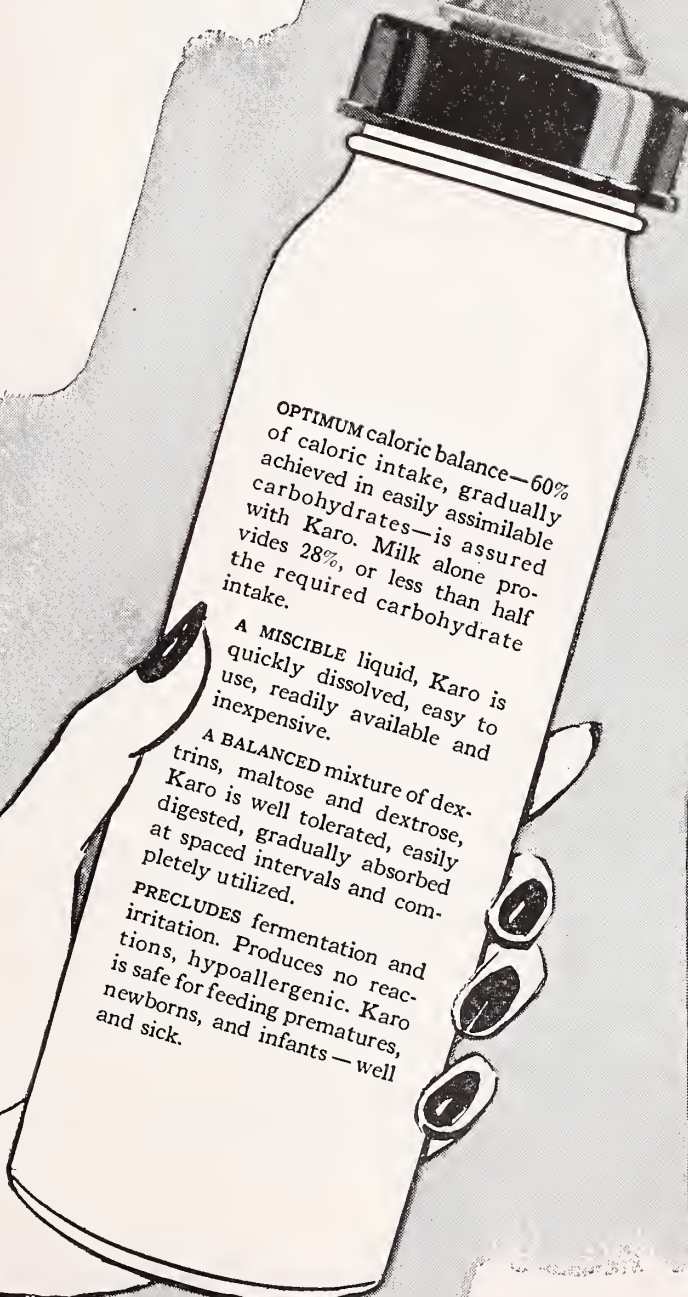
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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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## USE OF $I^{131}$ IN THYROTOXICOSIS

Experience at Hartford Hospital: 1949-1953

GEORGE B. McADAMS, M.D., *and* JOAN STIANO, B.S., *Hartford*

PRIOR to the summer of 1950, radioactive iodine was used at the Hartford Hospital in a limited manner, primarily for treatment of those thyroid carcinoma patients showing some affinity for iodine by tracer dose. The treatments were carried out under the direction of the late Dr. William T. Salter of the Department of Pharmacology of Yale University School of Medicine, and with  $I^{131}$  obtained from him. With the setting up of an Isotope Committee in December 1949, and subsequent approval by the Atomic Energy Commission for the use of  $I^{131}$ , patients began to be referred for laboratory confirmation of clinically suspicious hyperthyroidism. Radioactive uptake studies were combined with protein-bound iodine (P.B.I.) determinations, and results interpreted accordingly.

From the beginning, multiple determinations (over a 24 hour period) of thyroid uptake of administered  $I^{131}$  have been exclusively used as the basis for study, and it soon became apparent that many different curves of uptake within the first day were experienced. A mathematical equation was devised depicting these curves, incorporating the slope of accumulation during the first four hours, maximum uptake at eight hours and ratio of the eight hour value to the twenty-four hour one. This formulation was interpreted as a measure of the thyroid's avidity for and organic binding of iodide, and its subsequent release into the blood as thyroxine. It was expressed in terms of milligrams of thyroxine secreted by the gland per day and was and is known as the thyroid metabolic rate—T.M.R. This could be compared with the P.B.I. level in the blood by the following: By giving synthetic l-thyroxine daily over a period

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### SUMMARY

A general discussion of the use of  $I^{131}$  at the Hartford Hospital for diagnosis and treatment of hyperthyroidism has been given with details of the significance of radioactive uptake curves as compared with single per cent uptake readings.

Tables are presented giving the number of tracer studies and number of hyperthyroids diagnosed by this method, and also the results of therapy with  $I^{131}$ .

Illustrative cases concerning problems both in diagnosis and treatment are included. Stress is laid upon the importance of multiple determinations over a twenty-four hour period together with protein-bound iodine studies.

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of time to athyreotics (made so by total ablation of the gland for malignancy), Rosenblum<sup>2</sup> had obtained in Salter's laboratory a straight line relationship between the amount administered and the P.B.I. levels. For example, the feeding orally of 0.21 mgm. of l-thyroxine daily over a period of a few days produced a constant value of 5.0 micrograms per cent P.B.I. It was then assumed that in any person with a P.B.I. of 5.0, the intact thyroid is secreting the same amount of thyroxine, i.e., 0.21 mgm., as the athyreotics receive in substitution therapy. With this information we compared the T.M.R. as determined by uptake studies with the P.B.I. levels of a

*From the Departments of Pathology and Radiology*



number of patients during 1950 and 1951 from the Hartford Hospital and the results were subsequently reported.<sup>2</sup>

The main point to be emphasized is the high coefficient of correlation, i.e., 0.87, between the T.M.R. and the P.B.I. levels, much higher than the single twenty-four hour uptake percentage and P.B.I., or the B.M.R. and P.B.I. This has given us two completely objective, independent tests of thyroid function, one radioactive, the other chemical, each expressible in terms of amounts of thyroxine made in the gland and released in the blood in a unit time, and so they reinforce one another in the diagnostic workup of suspicious cases. As a matter of convenience we now report uptake curves in terms of expected P.B.I. levels and compare with actually determined values, rather than expressing both in fractions of mgms. of thyroxine.

As pointed out previously,<sup>3</sup> we have not found the conversion ratio, the proportion of circulating radioactivity that is protein-bound (i.e., radiothyroxine), to be as accurate a measure as these two tests. Recently we have begun to utilize the blood determination 24 and 72 hours after  $I^{131}$  administration to test the radioactivity in a given amount of serum (2 cc.). As Silver pointed out,<sup>4</sup> there is a wide separation of normal and abnormal values, the turnover in the hyperthyroid gland being so rapid as to push out into the blood a relatively large amount of radioactive identifiable thyroxine in a short period of time. There is no overlap of normals and hyperthyroids by three days. This should prove a valuable third test of thyroid function to supplement the other two. We have abandoned the use of urine determinations of radioactivity for two reasons. One is the almost congenital inability of outpatients to collect all of a 24 hour specimen. The other objection is similar to the single 24 hour radioactive per cent uptake by the gland. Being able to state

that this or that patient excreted only 30 per cent of the radioactive dose in 24 hours tells us that the thyroid and body are avid for iodide but does not tell us whether the thyroid is hyperfunctioning as in thyrotoxicosis or is merely a large, somewhat stagnant reservoir as in nontoxic goitre. Neither the urine determinations nor the single 24 hour per cent uptake by the gland can differentiate between these two conditions.

To obtain the T.M.R. the patient arrives at the x-ray therapy department at 9 A. M. in a fasting state and receives 50 microcuries of  $I^{131}$  as dispensed by Carbon and Carbide Chemical Co., Oak Ridge, Tennessee, in a glass of tap water. He or she returns at 1 P. M., 4:30 P. M., and again at 9 A. M. the next day for uptake determinations. An incidental finding has been that the 4 hour reading gives values most closely relating to the T.M.R., and if ever multiple determinations were abolished, that rather than the 8 or 24 hour value would be substituted.

As is obvious to all, the greatest difficulty encountered in diagnosis is the problem of iodide contamination possible from the ever growing list of drugs and opaque dyes—from cough syrup to diodrast. When, as occasionally happens, there is a discrepancy between the P.B.I. and the T.M.R., it is difficult to decide sometimes if a gallbladder series of six months ago is contributing a contaminating amount of iodine or if it truly represents some extreme of variation between the two tests. A recent publication by Benotti<sup>5</sup> emphasizing the value of performing routinely total iodide as well as P.B.I.'s will probably prove quite valuable in this regard and work on this phase to discover if this or that P.B.I. value is a true one or reflects contamination from a large total circulating iodide is being undertaken in the Hartford Hospital.

We have found that the use of  $I^{131}$  for diagnosis of hyperthyroidism to be a very easily carried out

TABLE I  
 $I^{131}$  TRACER STUDIES 1949-1953

YEAR	TOTAL WITH DIAGNOSIS OF HYPERTHYROIDISM										
	TOTAL		SEX					AGE			
	TRACERS	PATIENTS	TRACERS	PATIENTS	SEX		10-20	20-30	30-40	40-50	50+
					MALE	FEMALE					
1949-1950	20	20	5	4	—	4	1	—	—	1	2
1950-1951	123	109	33	27	4	23	1	5	6	6	9
1951-1952	140	129	27	21	3	18	—	2	7	3	9
1952-1953	219	180	51	40	5	35	—	8	8	9	15
Total	502	438	116	92	12	80	2	15	21	19	35

procedure with no danger or discomfort to the patient. All in all, the ease of administration and the relatively high degree of accuracy when combined with the P.B.I. make it an excellent diagnostic test—in the absence of previous therapy directed at the thyroid. In addition, the degree of activity of adenomata, the presence of substernal goitre and of ectopic thyroid tissue are readily determined along with the presence of toxicity. Table 1 shows our experience in diagnosing thyrotoxicosis by these methods described above.

The following are six cases illustrating various facets of diagnosing hyperthyroidism and problems connected with them.

#### CLASSICAL HYPERTHYROIDISM

Mrs. L. A., 21 year old white female with complaint of protruding eyes for 6 weeks and eight pound weight loss in spite of excellent appetite, extreme fatigue, heat intolerance, and slight tremor. Pulse 140. Diffuse moderate thyroid enlargement. B.M.R. + 65 per cent.  $I^{131}$  studies comparable with P.B.I. of 13.2 micrograms per cent. Actual value as determined was 16.0 micrograms per cent.

#### THYROCARDIAC DISEASE

Miss C. H., 39 year old white female with initial complaint of ankle edema. Diagnosis of cardiac decompensation was made but she did not respond to digitalis. Pulse 135; blood pressure 160/80. There was a systolic apical murmur transmitted to the axilla. Pulse was never below 120. Thyroid not enlarged. Did have vague eye symptoms, fine tremor to fingers, a complaint of chronic fatigue and nervousness, and preference for winter weather. B.M.R. was + 63. There had been no weight loss or increase in appetite.  $I^{131}$  studies showed a 55.5 per cent uptake in 24 hours and the curve of uptake was comparable with an expected P.B.I. of 17.6 micrograms per cent. Its actual value determined was 14.5 micrograms per cent. (She has subsequently been successfully treated by one dose of 6 millicuries of  $I^{131}$ .)

#### NONTOXIC GOITRE

Mrs. H. B., 32 year old white female with chief complaint of irritability, four pound weight loss in six months, heat intolerance, menstrual irregularity, palpitations, tremor of hand, and questionable exophthalmos. There was a fullness in the neck in the region of the thyroid. Cholesterol was 199 mg. per cent, B.M.R. + 32 per cent and 24 hour uptake of  $I^{131}$  45 per cent. But the curve of uptake demonstrated an expected P.B.I. of 7.4 micrograms per cent and the actual P.B.I. was 6.3 micrograms per cent. The final opinion was that she represented a nontoxic goitre with high total  $I^{131}$  collection but not a hyperthyroid curve of function.

#### NERVOUS WITH RAPID BREATHING AND ELEVATED B.M.R.

Mrs. T. F., a 42 year old obese white female with a past history of two thyroid operations fourteen and fifteen years previously for "toxic goitre." Present symptoms of tachycardia, nervousness, and slight prominence of eyes. Referred because of a B.M.R. of + 31 per cent. Uptake 28 per cent in

24 hours and curve comparable with a P.B.I. of 5.8 micrograms per cent. Actual value 6.5 micrograms per cent.

#### IODIDE-CONTAINING DRUG AND THE RESULTANT CONFUSION

Mrs. R. R., a 61 year old white female with goitre history of twenty-five years. Well until two weeks prior to admission when she began having increase in cough, and the appearance of dyspnea and orthopnea. Extremely enlarged gland, extending substernally (by x-ray). Patient admitted taking potassium iodide or Lugol's solution for year including the night before admission. Three days later the uptake studies gave values approaching a P.B.I. of 2.0 micrograms per cent with a 6.6 per cent uptake in 24 hours; but the actual P.B.I. was greater than 25 micrograms per cent—the disproportion proving the iodide contaminating effect of Lugol's.

Mrs. E. S., a 51 year old white female, a cardiac who was investigated as a thyroid status because of conflicting B.M.R.'s. Took Lugol's solution for 10 days two months prior to the  $I^{131}$  uptake test which was only 3.2 per cent in 24 hours and consistent with a P.B.I. of 2.2 micrograms per cent. The actual P.B.I. of 11.1 micrograms per cent reflects residual iodide from the Lugol's solution of eight weeks previous. (Usually 8-10 days is required for this contamination from Lugol's to become insignificant. Occasionally as in this case a much longer time must elapse.) Eight months later repeated studies resulted in normal findings with a 24 hour uptake of 28.8 per cent, the  $I^{131}$  curve consistent with a P.B.I. of 4.4 micrograms per cent, and the actual P.B.I. reported as 4.5 micrograms per cent.

Once the diagnosis of thyrotoxicosis is established and the attending physician expresses his wish for the patient to be treated with  $I^{131}$ , he or she is seen by a member of the Endocrine Committee and Isotope Committee for approval of  $I^{131}$  therapy. The criteria adapted to date are: (1) patient should be forty years of age or over; (2) the gland should not be nodular; (3) kidney function should be good; (4) the patient should not be anemic or leukopenic. On rare occasion, especially if a course of anti-thyroid medication has not been successful and operation is either refused or inadvisable from a medical standpoint, patients under forty years of age will be approved for  $I^{131}$  therapy. The "magic" figure of forty has been the dividing line thus far in an attempt to avoid the theoretical possibility of radiation-produced carcinoma in the younger age groups. Until 1965-1970, when a sufficient number of patients thus treated will have lived for 20 years and evaluated at that time as to carcinoma incidence, this highly improbable factor has to be considered. We do not believe it good practice to treat toxic adenomata unless no other means of therapy is possible. Surgery remains the treatment of choice for this condition for two reasons: dosage must be larger and success of therapy is more unpredictable,



and the significant incidence of carcinoma in single thyroid nodules makes their removal almost imperative.

The usual course of treatment includes an initial dose of 4-10 millicuries (most often 6) depending on toxicity, tendency to retain  $I^{131}$  in the gland as indicated by the ratio of the 8 to the 24 hour pickup, and estimated size of the thyroid. This latter factor is admittedly one of the most uncertain of all clinical evaluation of thyroid disease, and there are many reports in the literature stating the difficulty of competent observers arriving near the gram weight of the glands of different individuals. We make no attempt to do so beyond the easy categories of "small, medium, or large."

The treatment dose can be given on an outpatient basis (in contrast to the much larger doses for carcinoma). The patients experience no discomfort whatsoever, either at the time or 7-10 days later when the radiation reaction is at its height. They are informed that no dramatic effect will be observed, that they should begin feeling better after a few weeks—if the one dose is sufficient to make them euthyroid. They are told that they may need several treatment doses for cure and that they will be seen again every eight weeks for re-evaluation with another tracer dose and blood studies.

Adjunct to  $I^{131}$  therapy include antithyroid compounds such as propylthiouracil and tapazol which can be given one week after the  $I^{131}$  and continued until a few days before testing again. These drugs can alleviate symptoms in an extremely toxic patient and are reported<sup>6</sup> to help the production of the remission with radioiodine. In the patient with extensive exophthalmos, protection of the eyes can be achieved with the use of thyroid extract begun after maximum absorption of radioiodine by the gland is accomplished (8-48 hours).

There occasionally occur discrepancies when comparing the T.M.R. as determined by uptake studies and the P.B.I. value after therapy. Often when a patient becomes subjectively much improved, the uptake 8 weeks after  $I^{131}$  therapy will be normal, but the P.B.I. slightly elevated, although less than the original value. And later both will be found to be normal. The last of a residual excess thyroxine is the probable explanation for this at the time when the gland is, to all intents and purpose, making and releasing a normal amount of hormone. This "lag" of actual P.B.I. behind that expected from

the uptake is seen in case M. D. below. Rarely, however, more inexplicable differences occur—normal P.B.I. and elevated uptake after  $I^{131}$ , the reverse of what one would expect. In the final analysis it may well be that P.B.I. values do not necessarily reflect the absolute true state of thyroid function, as we would like to think it does. With the increasing knowledge concerning tri-iodothyronine, its probable quantitative difference in hyperthyroids as compared to normals, etc., we are arriving at the last great barrier to a thorough understanding of thyroid metabolism—the variables affecting the action of thyroid hormone on the end organs, cells. In other words, serum values of tri-iodothyronine and uptake studies utilizing this more "diffusible" form of thyroid hormone before and after  $I^{131}$  therapy may have more significance than the P.B.I. levels themselves, especially when the thyroid metabolism is reverting to normal under therapy. And with those investigations the present discrepancies of P.B.I. and T.M.R. may be explained.

Table 2 shows the results of treatment of twenty-six patients over the past three years in the Hartford Hospital.

TABLE 2  
 $I^{131}$  THERAPY 1949-1953

INITIAL DOSE	TOTAL PATIENTS	RESULTS		
		COMPLETE REMISSION	IMPROVED	NO IMPROVEMENT
5-6 M.C.	15	13	1	1
7-8 M.C.	1	1	—	—
9-10 M.C.	3	2	1	—
Multiple Rx with total in millicuries				
9-15 M.C.	4	2	1	1
16-23 M.C.	3	—	2	1
Total	26	18	5	3

It will be seen that the seventy per cent cure rate compares favorably with other clinics. There has been one recurrence, the event of which is rare after this form of therapy. This patient is included in the brief summary below of five patients illustrating details of therapy and results.

P. E.: Thirty-six year old colored female with classical symptoms and signs of thyrotoxicosis, corroborated by a P.B.I. of 13 micrograms per cent. A single dose of 6 millicuries of  $I^{131}$  was given, and patient seen eleven weeks later at which time she felt much better and had a nine pound weight gain. Uptake curve had dropped to normal limits and gave an expected P.B.I. of 6.2. Her actual P.B.I. at this

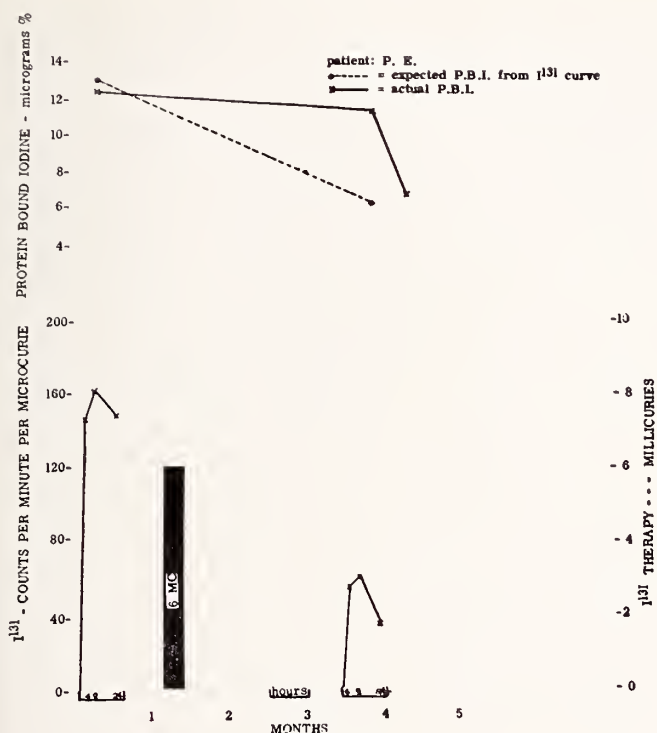


FIGURE 1

time was 11.4 micrograms present. A repeat two weeks later was 6.7 micrograms per cent, agreeing well with the last  $I^{131}$  study. It is postulated that the high level of circulating hormone persists for varying periods of time after thyroid gland function has been decreased by  $I^{131}$ . The fact that the patient is clinically much improved in spite of a P.B.I. of 11.4 is

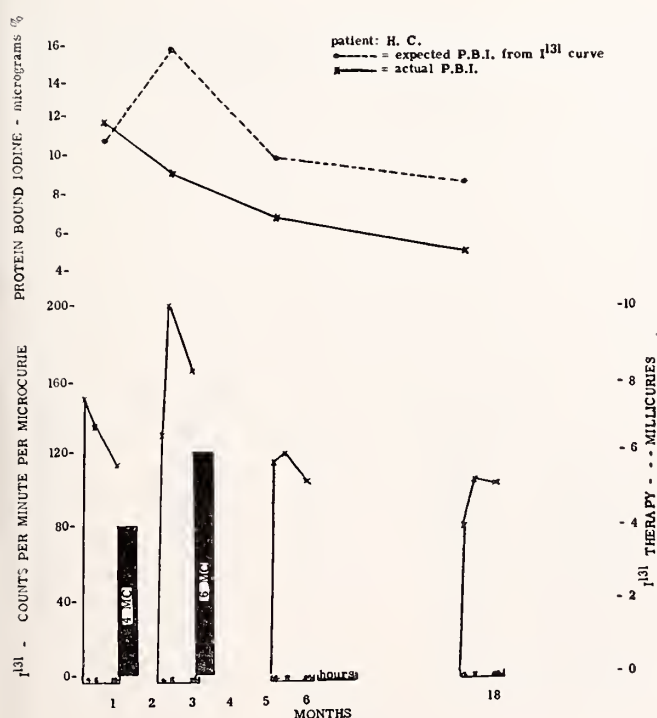


FIGURE 2

difficult to explain—possibly the matter of tri-iodothyronine, its greater proportional amount formed in a hyperactive gland (and conversely its relative decrease as the gland becomes normal). In any event she represents a cure with a single dose of 6 millicuries. As can be seen from Table 2, 50 per cent fall into this category.

H. C.: Forty-three year old white female with a one year history of weight loss, increased appetite, and heat intolerance. B.M.R. + 40. Patient was placed on propylthiouracil for nine months and obtained a satisfactory response, but she stopped the drug two months prior to  $I^{131}$  studies because her hair had begun to fall out. A diffusely enlarged, firm gland with a bruit was found, and her P.B.I. was 12.0 micrograms per cent and the expected P.B.I. from tracer studies 11.0 micrograms per cent. A dose of 4 millicuries was followed by re-evaluation in 6 weeks at which time she was for all practical purposes unchanged clinically but for slight improvement in nervousness. Her P.B.I. had dropped to 9.2 micrograms per cent, but her expected P.B.I. from the  $I^{131}$  curve was consistent with a P.B.I. of 16. She was given 6 more millicuries and seen again eight weeks later. At this time the nervousness had completely disappeared, pulse rate was slower, and she had gained seven pounds of weight in the past three weeks. P.B.I. at this time was 6.7. Two weeks later an uptake was compatible with a P.B.I. of 10.0 micrograms per cent. One year later she was again seen as a follow-up. She continued to feel excellently and had no symptoms or signs referable to thyroid disturbance. At this time the uptake was still slightly above normal, corresponding to an expected P.B.I. of 8.8; whereas the actual determined value was 5.0. This patient obtained satisfactory cure in two doses totalling 10 millicuries. The discrepancy of uptake and P.B.I.

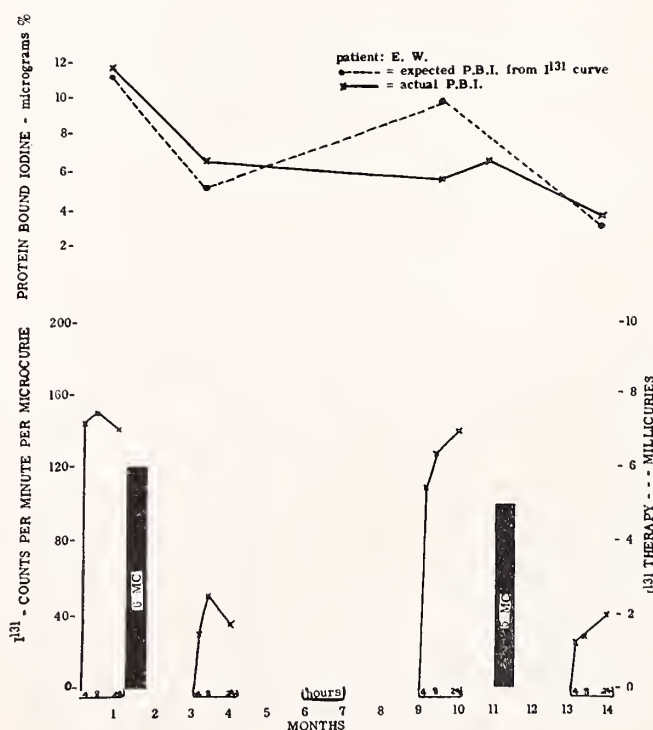


FIGURE 3



values is interesting to speculate upon. It is felt that the residual slightly elevated pickup reflects the more or less permanent glandular enlargement of the gland produced by her previous prolonged antithyroid medication.

E. W.: Thirty-seven year old white female had had a sub-total thyroidectomy eight years previously. Signs of recurrent toxicity during the intervening years and treated with antithyroid drugs. Because of persistent tachycardia, patient referred for diagnosis and treatment. With an expected P.B.I. from uptake studies of 11.2 and an actual one of 11.7, patient was treated with 6 millicuries. At time of next visit, eight weeks later, she was "100 per cent improved" with normal cardiac rate. As seen in the graph, the uptake and P.B.I. were normal at this time. Six months later she was seen again because of increasing fatigue and headaches for six weeks. Once again a tachycardia was present.  $I^{131}$  studies now showed an uptake curve at the initial level but with a different configuration. Her normal P.B.I. was confirmed a few days later (6.7 micrograms per cent). Because of the symptoms and uptake curve she was considered a recurrence in spite of a normal P.B.I. and accordingly 5 millicuries were administered. Two months later she was again euthyroid from every standpoint and has remained so. This case, the only recurrence we have had after  $I^{131}$  uptake at the time of her exacerbations of symptoms, is unexplainable at this time. All that can be said is that such discrepancies do crop up after treatment. What they signify is highly speculative.

M. D.: Thirty year old white male with history of one year of tremor of hands under stress conditions. This plus a one month weight loss of 15 pounds were only symptoms. Gland not palpable. B.M.R. + 40. Patient given tapazol for three weeks with some improvement but with persistent tachycardia and his doctor referred him for  $I^{131}$ . Uptake

curve reflected an expected P.B.I. of 13.4 micrograms per cent and actual determination was 14.1. The majority of the Endocrine Group who saw the patient questioned the length and dosage of therapy with tapazol (20 mg. q. d. the first week, 15 mg. q. d. the next two) as sufficient, but it was decided to go ahead with  $I^{131}$  treatment. Accordingly a single dose of 5 millicuries was administered. He did not return for followup for 11 weeks at which time he stated he was improved and had gained weight. His P.B.I. was 5.6 micrograms per cent. His uptake curve, however, demonstrated a surprisingly profound effect of the irradiation on his gland, the 24 hour collection being 3.2 per cent and curve comparable to a P.B.I. of 1.8. He was subsequently placed on 5 grains of thyroid extract daily because of hypothyroid symptoms. He received this medication for approximately three months when his doctor discontinued it at our request for we felt that this over radiation effect was temporary and the gland would function again if given the stimulus for doing so. He soon showed quite extreme hypothyroid symptoms together with an increase of 12 pounds. He was next seen six weeks after the exogenous thyroid was stopped at which time he showed only slight subjective improvement. Indeed his P.B.I. was 1.7 micrograms per cent. But his uptake curve demonstrated signs of thyroid response to circulating thyroid hormone deficiency, for it had risen from 3.2 per cent in 24 hours to 20.4 per cent and its curve corresponded to a normal P.B.I. With this reawakening of glandular function it was not long before the patient began to feel subjective improvement, and indeed two and one-half weeks later his P.B.I. had risen to 3.0. Complete return to normal was noted and his last P.B.I. was 6.8 micrograms per cent, ten weeks after the rise in radioactive uptake to normal was first noted. This was chosen as an example of

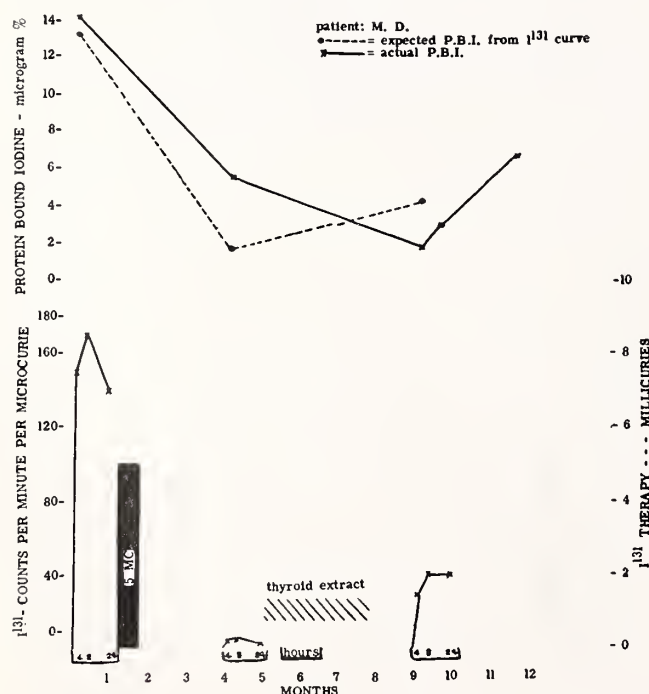


FIGURE 4

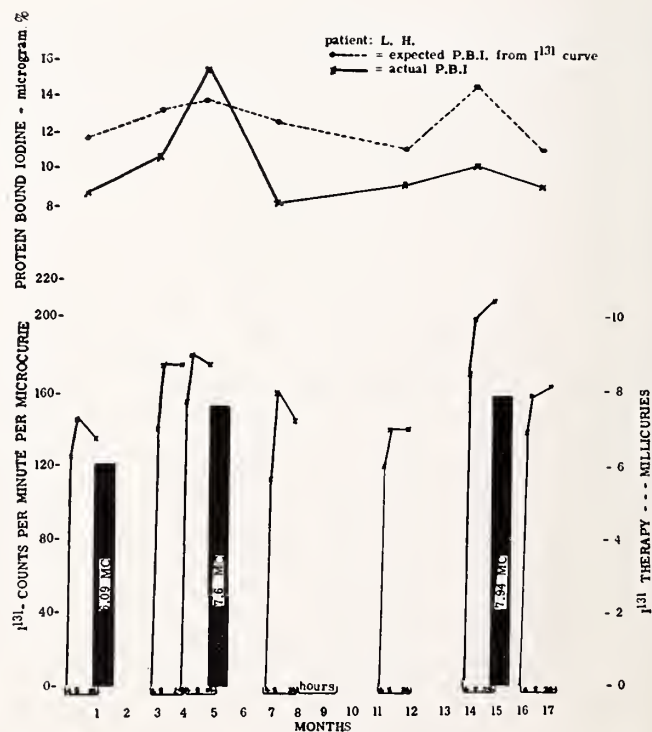


FIGURE 5

temporary hypothyroid state following  $I^{131}$  therapy for thyrotoxicosis with recovery after exogenous thyroid replacement therapy was discontinued.

L. H.: A thirty-five year old white female with a history of thyroid disease for twenty-two years. A partial thyroidectomy was performed for hyperthyroidism in 1941. A colloid adenoma was removed in 1951 from right side of neck. She was placed on propylthiouracil and did not improve following surgery. Right lobe still enlarged and nodular. Uptake studies in May 1952 were comparable with an 11.8 P.B.I.; the actual determined value of which was 8.9. The uptake over the right lobe was over three times that of the left and it was felt that a recurrent toxic adenoma was the underlying cause of her symptoms. Because of past surgery and apparent clinical failure with antithyroid drugs,  $I^{131}$  was given—6 millicuries initially. She felt a little better temporarily but never showed good improvement and in spite of two additional doses of  $I^{131}$  of 7.6 and 7.9 millicuries, respectively, with a total of 21.6 millicuries in 16 months, her P.B.I. ranged between 8.3 and 15.5 micrograms per cent with comparable  $I^{131}$  uptakes. She has subsequently undergone a right total thyroidectomy (January 1954) with pathological findings indicative of adenoma of the thyroid with scarring. Following this last operative procedure she has since been placed on thyroid extract and doing clinically well according to follow-up reports from the Out Patient Department.

In retrospect, those who have been cured elsewhere of their hyperthyroidism in the presence of nodules have usually required much higher  $I^{131}$  dosage (up to seventy-five millicuries), and most clinics are not satisfied with this method of therapy in toxic nodular goitre.

#### CONCLUSIONS

It is concluded that, if exogenous thyroid medication or iodide contamination can be excluded prior to testing, tracer studies as practiced in the Hart-

ford Hospital give a high degree of accuracy in the laboratory confirmation of suspected hyperthyroidism when combined with protein-bound iodine determinations.

Therapy with  $I^{131}$  for thyrotoxicosis is an effective, easy form of treatment in the absence of nodular goitre. It should be reserved for patients over forty years of age (unless other forms of therapy are contraindicated or have proved a failure) until results are obtained concerning the highly improbable factor of carcinogenicity of  $I^{131}$ .

The authors are indebted to Dr. Ralph T. Ogden, Department of Radiology, Hartford Hospital, for his advice in the preparation of this article.

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## MANAGEMENT OF THE PATIENT WITH ADVANCED CANCER

## Surgical Aspects

LEMUEL BOWDEN, M.D.

SINCE the term "advanced cancer" is open to varying interpretation, we have agreed to confine this term in this panel discussion to the patient with incurable cancer. This is a necessary restriction, since in certain cases a large bulky cancer of many months known duration may still be amenable to potentially curative therapy, while in other instances a cancer of seemingly acute onset and brief duration may nevertheless be totally incurable.

The treatment of a patient with incurable cancer is inextricably involved in the physician's general philosophy and in his concept of his mission and obligation to the sick and suffering. There are many physicians who, like the average layman, feel that cancer is essentially incurable and that, once the diagnosis has been established, all active therapeutic measures should be stopped and the patient allowed to die. With much more conviction is such therapeutic nihilism applied to the patient with incurable cancer.

The present discussion will seem pointless to the physician so minded. As cancer therapists, however, we strongly adhere to the opposite point of view. Recognizing that life itself is the universal "disease," if you will, to which we all sooner or later succumb, we feel that the physician's obligation to his patient is founded on the principle of preservation of life regardless of how hopeless the eventual outlook may be, provided that the extension of life so afforded is reasonably normal and free from acute suffering.

True palliation, as above defined, is often more difficult to obtain and to maintain in the patient with incurable cancer than is cure in the potentially curable patient. In striving for palliation each case has to be carefully evaluated on its own merits. Careful and mature clinical judgment is required to determine what active therapy, if any, should be given a patient with incurable cancer to achieve true palliation. Individualization of therapy is imperative. Nevertheless there appear to be several general

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## SUMMARY

In the management of patients with incurable cancer the place of surgery is relatively insignificant as compared with other forms of therapy. It is of fundamental importance to individualize all treatment offered to the patient with incurable cancer. Nevertheless, certain general indications for surgical therapy are recognized. These include hemorrhage, obstruction, pain, fungation of tumor, and coincidental surgical disease. By means of brief case presentations these indications for palliative surgery are illustrated.

indications for surgical treatment of the incurable cancer patient. (Table 1.)

TABLE I	
INCURABLE CANCER	
Indications for Palliative Surgery	
Hemorrhage:	
Acute	
Chronic	
Obstruction:	
Respiratory	
Gastrointestinal	
Biliary	
Urinary	
Vascular	
Pain	
Fungation	
Coincidental Disease	
Miscellaneous:	
Spinal cord compression	
Infection	

## HEMORRHAGE

Massive hemorrhage in a patient with incurable cancer may occur as a result of neoplastic invasion

or radiation necrosis of a major blood vessel. If not effectively controlled death will promptly ensue.

Case No. 1—J. B. This 45 year old bartender had had previous surgical, x-ray and radium therapy administered elsewhere for a squamous carcinoma of the right tonsil. On examination at Memorial Hospital on August 9, 1947 a 2 cm. necrotic ulcer was noted in the right tonsillar fossa, as well as induration and erythema in the skin of the right neck over an area 9 cm. in diameter. It was the feeling of the examiner that the findings were the result of radiation necrosis, and that no identifiable cancer was present. The patient was carefully followed, and healing of the tonsillar ulcer noted. Five months later, however, a definite mass was noted in the right neck. On February 25, 1948 a right radical neck dissection was performed for metastatic squamous carcinoma. Healing was retarded because of previously administered irradiation, and secondary pinch grafting was required. On the 32nd postoperative day the patient had a sudden severe hemorrhage from the operative wound requiring ligation of the internal carotid artery. Convalescence was prolonged, but otherwise uneventful.

Comment: Although this patient eventually died of residual and metastatic cancer, he was nevertheless afforded, by prompt surgical treatment of his acute hemorrhage, many months of comfortable living before his death came more than three years later.

Palliative surgery may be required in certain cases for hemorrhage of more chronic nature, as exemplified in the following case:

Case No. 2—T. H. This 54 year old office worker had had a palliative colon resection for adenocarcinoma performed elsewhere in October 1949. Peritoneal implants and enlarged peri-aortic nodes were found at the time of this resection. The patient recovered uneventfully from this procedure and remained in good health for 7 months. In May 1950 he noted the onset of occasional tarry stools, which increased in frequency and were later associated with episodes of hematemesis, weakness, anorexia and weight loss. The patient, on admission to Memorial Hospital, was found to be chronically ill but not in shock, with an enlarged and questionably nodular liver and a palpable spleen. Liver function studies were within normal limits. X-ray studies showed no esophageal varices but findings suggestive of a lesser curvature ulcer. Gastrointestinal bleeding continued episodically in spite of a rigid ulcer regimen following hospitalization, and multiple blood transfusions were required to raise an admission hemoglobin of 6.3 Gm. to normal levels. Because of persistent bleeding after four weeks of medical treatment in the hospital, the patient's abdomen was explored and subtotal gastrectomy performed (Figure 1) on December 14, 1950, in the face of multiple liver and peritoneal metastases. Actually the bleeding was not due to gastric ulceration, but to hitherto unrecognized esophageal varices. Interruption of collateral vascular channels by the gastric resection improved the bleeding. The varices were further treated by injection via the esophagoscope on two occasions. The patient died of cancer on April 11, 1951.

Comment: While survival of only four months

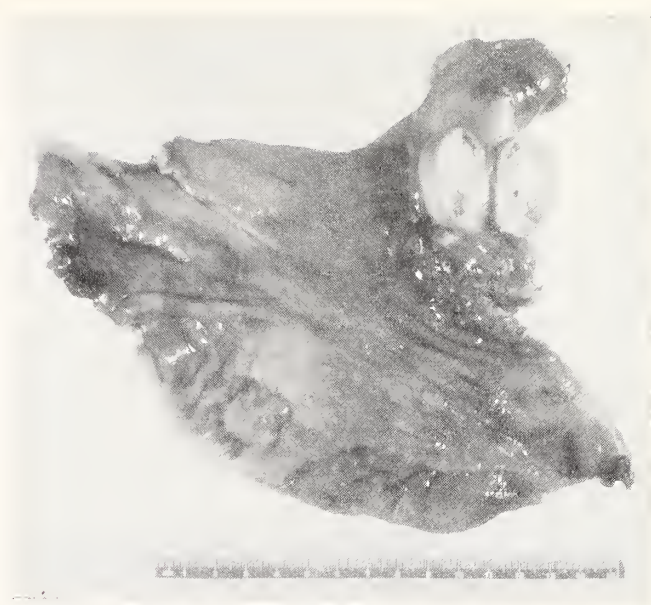


FIGURE 1

Case No. 2: T. H. Surgical specimen following subtotal gastrectomy for intractable bleeding, showing metastatic nodule secondary to adenocarcinoma of the colon, but no demonstrable mucosal ulceration. The cause of bleeding proved to be esophageal varices, which were improved postoperatively because of interruption of many collateral vascular channels by the gastric resection

following major abdominal surgery is questionable palliation from the objective standpoint, both the patient and his family felt the surgery well worth while.

#### OBSTRUCTION

The next most obvious indication for palliative surgery in selected cases of incurable cancer is mechanical obstruction of a vital anatomical channel or passage. Obvious examples of this indication include respiratory obstruction from an advanced cancer of the tongue or larynx in which tracheostomy may be indicated, biliary obstruction from a nonresectable cancer of the pancreas in which cholecystenterostomy or choledochenterostomy may be indicated, or urinary obstruction from an inoperable prostatic cancer in which transurethral resection may be indicated. Gastrointestinal obstruction is a frequent finding in abdominal carcinomatosis, as exemplified in the following case:

Case No. 3—E. D. F. A 42 year old housewife had had bilateral "cystadenomas" of the ovaries removed elsewhere in 1932. She then remained well until 1949 when, because of obstructive symptoms, she was re-explored elsewhere and diffuse ovarian carcinomatosis found. Intensive x-ray therapy to the abdomen was administered. Recurrent obstructive



symptoms one and one-half years later led to a transverse colostomy which, however, did not appreciably relieve the patient's symptoms. On admission to Memorial Hospital she was found to be emaciated, weighing only 75 pounds, with a large lower abdominal mass extending into the cul-de-sac. After careful preparation her abdomen was re-explored on May 3, 1951 and, in spite of diffuse carcinomatosis, a massive resection of the lower abdominal mass, reproductive organs, portions of ascending and sigmoid colon as well as two segments of obstructed small bowel was performed. The patient's convalescence was surprisingly smooth.

Comment: This patient is living almost three years since her radical surgery in spite of known residual cancer. She weighs 100 pounds, has taken a secretarial job in addition to her housekeeping, and is free of significant complaints.

In addition to respiratory, gastrointestinal, biliary and urinary tract obstruction, one may find in the incurable cancer patient signs of vascular obstruction, either arterial or venous. Embolectomy combined with sympathectomy may be well worthwhile in certain cases of acute arterial obstruction, while palliative removal of a neoplasm causing compression of major venous channels may similarly be symptomatically rewarding.

#### PAIN

It may be stated that in general the pain of incurable cancer is more often treated by medical or radiotherapeutic methods. Yet in certain instances surgical intervention is indicated. The usefulness of cordotomy in the relief of intractable pain is sufficiently recognized to require no further comment here. Occasionally direct surgical attack on the neoplasms itself is warranted for the relief of pain.

Case No. 4—O. B. A 45 year old housewife had had a sigmoid resection and right oophorectomy for adenocarcinoma of the sigmoid metastatic to the ovary performed elsewhere in August 1951. She remained well for a few months but then developed steady lower abdominal pain coincident with the appearance of a pelvic mass. On admission to Memorial Hospital the patient was found to have a huge, relatively fixed lower abdominal mass and roentgenographic evidence of right pleural metastases. After considerable study and an uneventful trial of experimental therapy in the Research Division, she was subjected to surgical exploration on September 18, 1952, and the large pelvic mass successfully removed (Figure 2). Liver metastasis was identified at this exploration.

Comment: The patient was symptomatically much relieved for several months, although never completely broken of drug addiction. Her death was sudden from a cerebral accident (? metastasis) ten months following surgery.



FIGURE 2

Case No. 4: O. B. Surgical specimen of resected pelvic mass, weighing 3900 Gm., believed to represent a huge Krukenberg tumor of the left ovary. The mass completely encompassed the uterus, the cervix of which is identified by the arrow.

#### FUNGATION

A most distressing complication of advanced cancer is ulceration of the neoplasm through the overlying integument with its sequel of secondary infection, hemorrhage, fluid loss and offensive odor. Although in some instances fungation of cancer is not incompatible with cure, if it occurs at all it is usually found in patients with incurable cancer. Surgical removal of the fungating tumor is frequently justified and welcomed by both patient and family.

Case No. 5—S. A. A 37 year old sheetmetal worker had had a tumor of the left buttock excised elsewhere in July 1949, and a recurrent tumor removed elsewhere in December 1949. On admission to Memorial Hospital the patient presented a 25 × 25 cm. fixed nodular mass replacing the entire left buttock and extending beyond the midline, with ulceration and fungation in its center. Palliative x-ray therapy was administered to the lesion from February 27, 1950 to April 3, 1950 for a total dose of 3000 r × 2 (air dose), 250 KV technique, with definite shrinkage in size of tumor (Figure 3). Electrocautery excision of the entire tumor was carried out on April 10, 1950 and secondary grafting subsequently performed. The lesion was classified as a pleomorphic cell sarcoma, probably myogenic. Healing was delayed but eventually complete.

Comment: The patient remained in good general condition until about six weeks before his death on



FIGURE 3

Case No. 5: S A. Fungating pleomorphic-cell sarcoma of the left buttock, following palliative roentgen therapy and prior to palliative electrosurgical removal

December 13, 1950 from pulmonary hemorrhage due to metastases. An eight month survival is not particularly long, but the comfort afforded the patient by removal of the fungating tumor proved the effectiveness of the palliation.

#### COINCIDENTAL DISEASE

Occasionally encountered in the management of incurable cancer patients is the development of totally unrelated disease which requires surgical treatment.

Case No. 6—C. A. S. An 11 year old school girl was found to have an acute stem-cell leukemia five months before Memorial Hospital admission. She had been given ACTH originally but had recently been treated as an outpatient with 6-mercaptopurine and O-diazoaceto-l-serine with partial remission of the leukemic process. Because of the spontaneous development of abdominal pain and signs of an acute abdomen, she was admitted to the hospital as an emergency and an acute suppurative appendix removed. Convalescence was uneventful.

Comment: The incurable cancer patient appears to be as susceptible to acute appendicitis, strangulated hernia, perforated peptic ulcer, etc., as the cancer-free person of comparable age, sex and constitutional makeup, but appears to tolerate inadequate or indifferent treatment of these serious surgical conditions poorly, as might be expected.

#### MISCELLANEOUS

There are probably many miscellaneous indications for surgical treatment of the incurable cancer

patient. Two that seem well worth mentioning are exemplified by the following two cases:

Case No. 7—K. A. A 47 year old housewife was found to have incurable follicular and alveolar carcinoma of the thyroid at the time of a pathologic fracture of the left femur in September 1950. The fracture was treated by open reduction and postoperative x-ray therapy elsewhere. At the time of admission to Memorial Hospital in April 1953 the patient was found to have radiographic evidence of widespread osteolytic metastases. In preparation for subsequent palliative therapy with radioactive iodine she was submitted to total thyroidectomy on May 13, 1953. Pathological study confirmed the presence of follicular and alveolar adenocarcinoma primary in the right lobe of the thyroid. On the 7th postoperative day the patient rather suddenly developed motor, sensory and reflex changes indicative of cord compression at D-5 and D-6 level. (Figure 4.) Emergency laminectomy and removal of metastatic cancer was performed on May 21, 1953, by Dr. Herbert Parsons. Palliative x-ray therapy to the region of decompression was subsequently given. She has had complete return of motor and sensory function in the lower extremities, although still dependent on crutches because of the old left femoral fracture.



FIGURE 4

Case No. 7: K. A. Roentgenogram demonstrating metastasis of follicular and alveolar carcinoma of the thyroid to the thoracic spine. A soft tissue mass to the left of D-5 and D-6 is noted, as well as total destruction of the transverse process of D-6 and head and neck of the left 6th rib. Spinal cord compression at this level with early paraplegia was successfully corrected by prompt surgical intervention



Comment: While this patient is still under palliative x-ray therapy to various areas of osseous metastasis, she is up and about on crutches, thanks to the prompt surgical decompression of a spinal metastasis with impending transverse myelitis.

Case No. 8—R. M. A 55 year old executive had been subjected to a right thoracotomy elsewhere for an epidermoid carcinoma of the right upper lobe which had directly invaded the subclavian vessels. An infected hemothorax developed and at the time of admission to Memorial Hospital the patient, in addition, presented metastatic cancer in right lower neck nodes. Palliative x-ray therapy was instituted to the right upper chest and lower neck. Because of continued spiking temperature and other signs of undrained sepsis, an open thoracotomy was performed on January 25, 1954 by Dr. John L. Pool with subsidence of signs of sepsis.

Comment: While it is much too soon to determine whether true palliation has been achieved in this

case, it is certain that the pleural infection and resulting toxemia could not have been controlled by means other than surgical.

#### CONCLUSIONS

If the physician follows the principle of preservation of life so long as living can be maintained in relative comfort, then he will be occasionally required to employ surgical treatment in selected cases of incurable cancer. While individualization of treatment is imperative for successful palliation, it is apparent that surgical treatment may be necessary when the incurable cancer patient has hemorrhages, becomes obstructed, has intractable pain, presents fungation of tumor, develops coincidental surgical lesions, or presents certain other miscellaneous complications.

## SIMULTANEOUS BILATERAL BREAST CANCER

### A Report of Two Cases

JAMES R. CULLEN, M.D., FRANCIS P. CATANZARO, M.D., and GREGORY T. O'CONOR, M.D.,  
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IT has been evident in the recent literature that the incidence of bilateral breast cancer is on the increase. However, the simultaneous occurrence of bilateral breast cancer continues to be a rare clinical entity. The incidence of bilateral cancer varies from 12.9 per cent reported by Jordan and Keyes to about 2 per cent as reported by Finney et al. These statistics are based on series of cases, mainly consisting of nonsimultaneous bilateral breast lesions and do not at all indicate the relative incidence of simultaneous breast cancer. For example, in the series of 53 cases reported by E. L. Keyes, only two patients presented simultaneous bilateral breast cancers. The remaining patients had a time interval between involvement of the two breasts ranging from two months to seventeen years. In 17 patients the interval was unknown. In the series reported by Lewis and Reinhoff 1.5 per cent of the cases had bilateral breast cancers on admission.

One of the authors, J.R.C., reported a case of simultaneous bilateral breast cancer in the CONNECTI-

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#### SUMMARY

One case of bilateral simultaneous breast cancer with lesions of microscopically proven origin is reviewed. This patient is alive and well five years after staged bilateral mastectomy.

A second case of bilateral simultaneous breast cancer is presented together with a discussion of the pathological findings. Reference is given to the rising incidence of bilateral breast cancer and should cause serious thought regarding the question of prophylactic simple mastectomy in the other breast

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CUT STATE MEDICAL JOURNAL of November 1949. This patient is alive and well without evidence of disease five years after bilateral radical mastectomy.

We will briefly review this case and present one other case of bilateral simultaneous breast cancer together with a discussion of the pathological findings in each patient.

#### CASE HISTORY

A 45 year old white widow entered St. Francis Hospital on December 12, 1948 with a history of having noted a mass in her right breast near the edge of the nipple about six months before admission. It was described as about the size of a "robin's egg" and was not painful. She sought medical advice in October and again a week before admission. At that time a small mass was noted in the left breast. Systemic history was essentially negative as was the past history, except for "jaundice as a child following scarlet fever." Her menses were still regular. On physical examination the positive findings were limited to the breasts. The right breast had a 2 cm.  $\times$  2 cm. hard mass which was felt just above and lateral to the nipple and a small portion of the mass was adherent to overlying skin. In the left breast there was a 1 cm.  $\times$  1 cm. firm, freely movable mass in the upper inner quadrant. On December 13 both breasts were prepared as for radical operation. A block of tissue encompassing the tumor mass and nipple was excised from the right breast and a small mass of tissue including the tumor was resected from the left breast. Frozen section on each tumor was reported as carcinoma. A right radical mastectomy was done using a triangular flap incision. Ten days later a left radical mastectomy was done with a similar technique.

#### PATHOLOGY REPORT

The specimens were submitted to L. P. Hastings, M.D., and J. W. Thayer, M.D. They stated that the material submitted from both breasts confirmed the original report that both tumors were carcinomata which anatomically and cytologically were essentially similar. Both were intraductal and both exhibited areas of lobular carcinoma. The neoplastic growth in the right breast was more advanced and presented transition from the above types through a medullary type to a highly scirrhous type. Due to the fact that both exhibited intraductal carcinoma without evidence of metastasis to other sites, the tumors were considered to be of an independent and separate origin. It was noted that the clinical history, the comparative size of the growths, and the greater histological variation of the tumor in the right breast substantiated its claim to priority.

#### CASE HISTORY II

A 63 year old white married female was admitted to St. Francis Hospital on November 9, 1953 with a history of having noted the presence of a small lump in the upper outer aspect of each breast about four months prior to admission. They were non tender and did not increase in size. She denied weight loss, cough, chest pain, arm edema, or nipple discharge.

The only significant findings in her past history were (a)

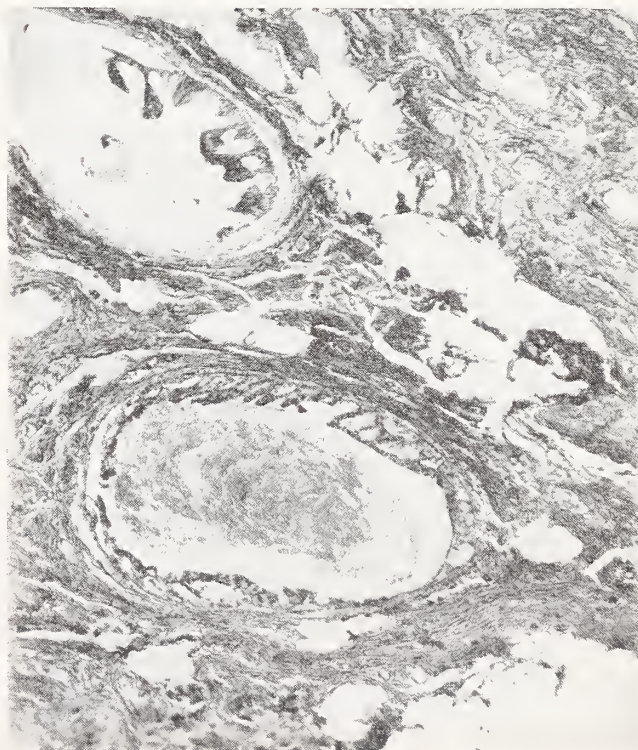
bilateral salpingo-oophorectomy in 1934, (b) the presence of a cardiac arrhythmia during the past five or six weeks being treated with Digitoxin.

The positive physical findings were limited to both breasts. Located in the upper lateral quadrant of each breast was a 2 cm.  $\times$  1.5 cm. hard, irregular, very slippery mass. These were non tender and not deeply attached, however the lesion on the left was partially fixed to the overlying skin. Slight dimpling was evident with the patient in the sitting position. Examination of the axillae was negative on the right, however in the apex of the left axilla was felt a firm 1 cm. in diameter non tender node. The admission laboratory studies and x-ray survey for metastasis were essentially within normal limits.

On November 10, 1953 bilateral frozen sections were done and both were reported as positive. Bilateral radical mastectomies were performed. The patient tolerated this extensive procedure very well and had an uneventful postoperative course with the exception of a mild adynamic ileus which developed on the fourth postoperative day. This responded well to the usual conservative measures.

#### PATHOLOGICAL REPORT

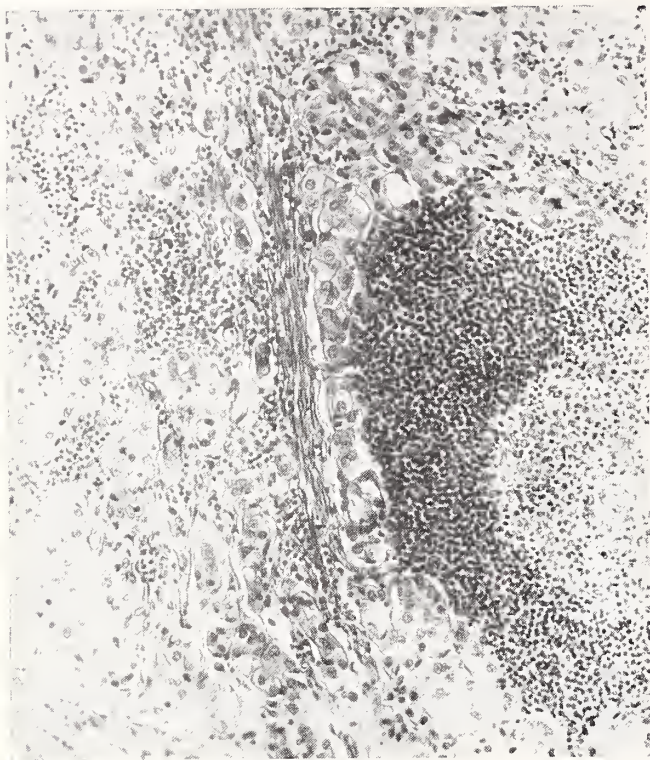
Gross: The right and left breasts are submitted with attached pectoralis muscles and axillary tissues. Both nipples are erect and the skin surfaces are smooth without dimpling or retraction. In the upper outer quadrant of each breast, just beneath the skin surface, there is found a discrete hard nodule measuring approximately 2  $\times$  2  $\times$  1 cms. This lesion has irregular borders and appears to be infiltrating the surrounding tissue. They cut with a gritty sensation and



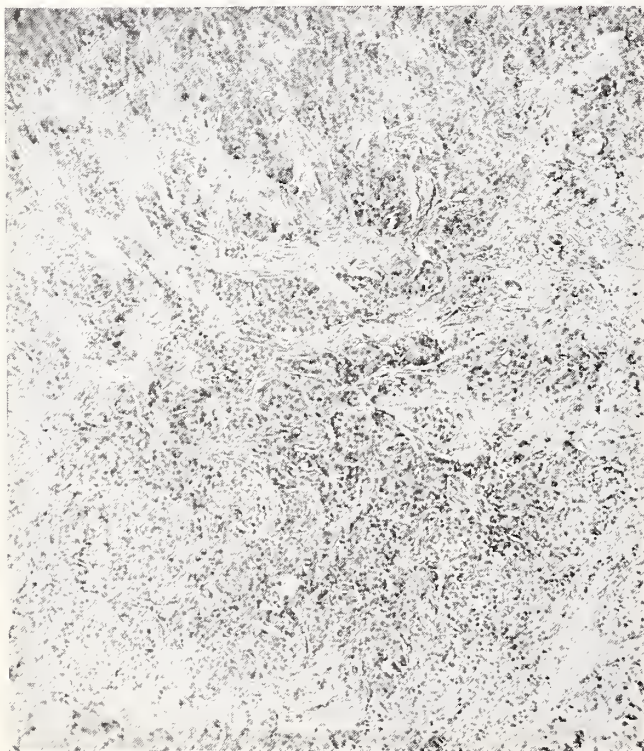
CASE II, FIGURE 1

Tumor right breast





CASE II, FIGURE 3  
Lymph node, left axilla



CASE II, FIGURE 2  
Tumor, left breast

have a grayish-pink color. The remaining breast parenchyma shows atrophy and diffuse fatty replacement of the glandular elements. Two lymph nodes are found in the right axillary fat and six are found on the left side. Two of the latter show gross evidence of metastatic tumor. Frozen section done on both breast tumors prior to radical mastectomy confirmed the gross impression of bilateral carcinoma.

**Microscopic:** The lesions in both breasts proved to be infiltrating carcinoma. The tumor on the right is characterized by a rather pleomorphic growth. In most areas there is poor differentiation with only abortive gland formation. There are, however, foci of recognizable intraduct carcinoma. There is little fibrous tissue production and the surrounding fat is infiltrated. On the left the neoplasm is highly anaplastic, the cells occurring as small irregular clumps and strands as a desmoplastic plane. Gland formation is not readily apparent. The adjacent breast tissue is benign and atrophic in both breasts. The lymph nodes from the right axilla show almost complete fatty replacement and no tumor, while two of the left axillary nodes contain metastatic tumor microscopically identical with the corresponding breast.

#### DISCUSSION OF PATHOLOGY

It has been suggested by Warren and Gates that the full criteria should be fulfilled to consider independent origin for bilateral breast cancer. (1) Each of the tumors must present a definite picture of malignancy. (2) Each must be distinct. (3) The possibility of one being metastasis from the other must be excluded. The latter statement is obviously the most pertinent and difficult to evaluate in a given case and its fulfillment must necessarily depend on a number of other facts and observations. In many cases a time interval between the finding of the two lesions enters into consideration. Histological differences in bilateral tumors frequently are difficult to establish since the great bulk of breast carcinomas show a fair degree of anaplasia and even more important is the very frequent growth pattern and cellular variation within a single tumor. It is not at all uncommon to find intraductal, lobular, and epidermoid carcinoma in the same lesion.

Case II presented above easily fulfills the first two criteria. The following points, although they do not categorically exclude the possibility of contralateral metastasis, strongly suggest an independent origin for each lesion. (1) Both tumors were located in the upper outer quadrant of the breast. Lesions in this position are much more apt to metastasize to the axilla than to the opposite side. (2) The lesions were of the same size. This of course in itself means little since metastatic lesions can be much larger than the primary. (3) The tumor in the left was

totally anaplastic and showed an identical microscopic picture in the metastatic nodes. The tumor on the right, however, did not have axillary node involvement and the possibility of its being metastatic from the left side is somewhat obviated by the fact that within it were found areas of infiltrating intraductal carcinoma.

The autochthonous bilateral carcinoma of the breast may be looked upon as a variation in the concept of the multicentric origin of cancer. This idea has been given support in studies of the stomach, lung, and bladder. In these organs we postulate a carcinogenic stimulus which involves an area or multiple areas in a single region with resultant uncontrolled growth of multiple cells. If we

apply the same concept to the breast we should expect to find many bilateral and single tumors in those cases where the stimulus is postulated to be of internal or hormonal origin.

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## THE MEDICAL PROFESSION AND THE CONNECTICUT WORKMEN'S COMPENSATION ACT

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### SUMMARY

The purpose of the Connecticut Workmen's Compensation Law, adopted in 1913, was to place the cost of industrial accidents on the employer, to provide the injured employee, or his family in case of his death, with a definite sum of money based on his wages, and to provide the injured employee full medical or surgical care, necessary hospital and nursing services. Connecticut has one of the most liberal compensation laws in the nation.

Medical testimony in compensation hearings is discussed and a comparison of methods of conducting the same with other states is made. Differences of opinion often exist in medical testimony and in estimating permanent disabilities. The medical profession in Connecticut has been remiss in not standardizing a method of disability evaluation.

Rehabilitation is a very important part of the medical care of the injured workman. If the physician is

not prepared to carry out proper rehabilitation therapy he should send the patient to a rehabilitation clinic. One of the best methods of rehabilitation is some form of gainful occupation during the convalescent period.

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THE Connecticut Workmen's Compensation Act was adopted in 1913 and became effective the following year. Two of the main purposes of this compensation law were to eliminate liability based solely on the employer's negligence and the employer's defense that the employee or co-worker was negligent. Previous to the enactment of this law an injured workman's only recourse was through a formal civil suit, usually a long and expensive process which very few injured workmen were able to undertake.

The philosophy underlying compensation law was that responsibility for industrial accidents arising out of and in the course of employment should be regarded as a proper charge in the cost of operating the employer's business. This idea, in effect, transferred the cost of industrial accidents from the worker and employer to the consumer.



Another purpose of the compensation law was to provide the injured workman with a weekly stipend while he was unable to work, or, in the case of death, to pay this stipend to his dependents for a specified number of weeks. The weekly payment was based on a percentage of the average weekly wage for the 26 weeks preceding the accident with specified minimum and maximum limits. These limits are subject to revision by the State Legislature. No one will dispute the fact that adjustments should be made from time to time in the amount of these payments to approximate the cost of living and the prevailing wage scale. Adjustments upward, however, should not be increased to the point where they encourage malingering or make laziness profitable.

A third aim, and the one with which we of the medical profession are chiefly concerned, was that the injured workman should be provided full medical or surgical care, including necessary hospital and nursing services. In the event an injury resulted in a permanent total or a permanent partial disability, the injured workman was to receive an award in accordance with the schedule established by the Compensation Act. This schedule establishes values for different parts of the body in terms of compensation weeks, that is, weeks during which the employee will receive compensation payments. In the event an estimate of disability is required to effect a settlement, it becomes the duty of the medical profession to make this estimate.

It is quite apparent that the responsibility for carrying out this portion of the Compensation Act rests entirely with the medical profession. This means that we must provide adequate care and estimate disabilities as they occur. It is with that phase of the Compensation Act that this paper is concerned.

The State of Connecticut has one of the most liberal Compensation Acts of all the forty-eight states and territories. The following is an example of the Connecticut Act: effective October 1, 1953 weekly compensation payments to an injured worker are computed as 60 per cent of the average weekly wage with a maximum of \$40. This amount continues for life in cases of total disability. The allowance for medical care is unlimited as long as the injured person lives. The treatment, of course, must be for a condition accepted as compensable. The fees permitted to be charged are those customary in the community. There is no limit on the total bill, provided it is necessary and reasonable for the services

rendered. Only six other states, plus the District of Columbia and Puerto Rico, have medical benefits unlimited in time and amount. In some states, where there is a limit to medical expense, provisions are made to continue treatment in the event of an exceptional case.

According to the statistics of the State Labor Department, published in *Safety News & Views*, April 1953, there were 18,102 lost time work injuries in 1952. Such an injury represents one day or more lost from work. This represents a decrease of about 300 cases from the report of the year 1951. A break down to cover the parts of the body injured reveals that the back and spine with 3,178 cases lead all other injuries, as in 1951. Other injuries occurred in this incidence of cases: fingers, 2,615; legs, 1,776; feet, 1,744; hands, 1,689; arms, 1,650. The report estimates that medical, surgical and hospital expenses amounted to \$5,200,000. The report further stated that all injuries resulted in a loss of approximately 1,391,400 man days. This represents a loss in wages of \$13,914,000, estimating the average wage rate as \$10 per day. \$8,781,000 or 63 per cent of this wage loss was returned to the worker through Workmen's Compensation. The uncompensated wage loss of \$5,133,000 sustained by labor in these days of the high cost of living remains a serious problem to the injured workman and his family. These statistics do not cover the entire cost of medical care because the estimated expense was based only on reportable lost time cases. For every lost time case it has been estimated that there are four no lost time cases. These cases, of course, require medical attention with resulting medical expense. Unquestionably the total medical expense is much greater than that estimated by the State Labor Department.

#### MEDICAL TESTIMONY

In addition to the responsibility of treating a large volume of industrial accident cases, frequently we physicians have the added responsibility of testifying before a Compensation Commissioner should a case go to a hearing for a final disposition. When the point at issue is purely a medical one, the Commissioner must base his decision on the testimony offered. So many times there is such a wide divergence in medical testimony one wonders how the Commissioner can arrive at any conclusion. This disparity of opinion between medical witnesses has, in fact, been the foundation of considerable criticism of the medical profession.

The subject of medical testimony in compensation hearings has interested me for many years. In 1949 I wanted to learn how the other States handled medical testimony and I wrote to the chairmen of the Industrial Accident Boards in 47 States and three territories and requested a copy of their respective compensation laws. Replies were received from 38 States and three Territories. Any study of the compensation law of a State is only as up-to-date as the last meeting of the State Legislature. Undoubtedly changes have been made in many States since 1949. At that time, however, with only a few exceptions all hearings were conducted as informal civil suits before an administrative officer, with little regard for the rules of evidence. This is the procedure in Connecticut. In one New England State, if there were a conflict in the medical testimony the Commissioner could secure an independent examination. It was interesting to note that the fee for this was \$5, plus travel expenses. Another New England State allowed the Commissioner an independent examination but the examiner selected could not have testified more than three times during the preceding 12 months, regardless of the side for which he had appeared. In a few States provisions were written into the act to establish panels of doctors skilled in industrial diseases, chiefly the pneumoconioses, and they acted as a board to which medical problems could be referred. The method of selecting these panels seemed fair. Nominations of from three to five doctors were made by three of these various sources: the dean of a state medical school; the president of a state medical society; the council of a state medical society; the state Commissioner of Health; or, in one case, the Governor. From this panel each side was to select one member and the two so selected would select a third. A Commissioner would refer medical problems to this board. The board was empowered to hear witnesses, examine the claimant and, in the case of death, order an autopsy. After the board files its report with the Compensation Commissioner, or Industrial Accident Board, the States' statutes vary somewhat as to how the report was to be accepted. One stated the Commissioner could either accept or reject the findings. Another stated the findings were binding on all parties. From a medical standpoint, these panels seemed a reasonable solution of a medical problem. When these provisions in the various Compensation Acts were reviewed by higher courts, the statutes were held unconstitutional. The reviewing courts found many

reasons for their decisions. The basic reason was the fact that the party was deprived of due process of the law, that is, the right of a party to confront the opposing witness and cross examine him. Also, it was contrary to the traditional idea that the one who decides must hear.

In an attempt to obtain disinterested medical opinions, free of legal objections, there is an interesting experiment going on in New York City at the present time with regard to tort cases. Through the generosity of the Ford Motor Co. Fund and the Alfred P. Sloane Foundation the sum of \$40,000 has been made available to pay for independent medical examinations in personal injury cases. The program will operate through the nomination of a panel of experts by the New York Academy of Medicine. These experts will be selected from the various branches of medicine. From this panel the court will make designations as required of specially qualified doctors who will make examinations of the plaintiff in personal injury cases, and report as to the nature and extent of injury. The report goes to the court and counsel on both sides. If the case goes to trial, the doctor will be subject to call at the trial and, like any other witness, subject to cross examination. This does not prevent the parties from obtaining their own medical experts if they so desire. However, the hope behind this experiment of these qualified independent examiners is that their opinion will carry so much weight with the court and jury that eventually no attempt will be made to refute their opinion. This would end the battle of the experts and conserve many court days. This plan appears to have great possibilities in regard to personal injuries in tort cases but it is doubtful if it could be applied to compensation cases in small communities.

I have indicated some of the procedures that have been tried to bring a little order out of the divergence of medical testimony that occurs frequently. In a way, the fact that these steps have to be taken does not reflect credit on the medical profession. In all probability the system in vogue in this State, and in practically all others, in settling compensation cases, namely, by informal civil suits presided over by an administrative officer, will remain the accepted procedure. The medical witnesses will continue to give their testimony and no matter how bewildering it is to the administration officer, he alone will have to make the decision.

The question naturally arises, why do we have this wide divergence of medical opinion at times? It



might be well to analyze this point. First and foremost, a reasonable difference of opinion among the members of the medical profession over the years has made for progress. Therefore, a reasonable difference of opinion should be considered legitimate.

A difference of opinion is not limited to our profession but it is usually the basis of most formal civil suits. It is rare that even our highest legal tribunals render an unanimous opinion. They are usually divided. However, when the medical testimony in a given case is so widely divergent that it is difficult to realize the medical witnesses are talking about the same case, then something must be wrong. This situation frequently occurs when the complaints are purely subjective. A subjective complaint is one made by a patient of a condition perceivable only to him and it is not always evident to the examiner. Evaluation of subjective complaints with regard to claims for disability is always difficult. In this circumstance the aim of the examining physician is fairness to the injured person and the employer. He must make a careful and unbiased examination, which will give a sound, fair appraisal of the complaints.

It is conceivable that an examining physician for the defendant, who, after a thorough examination finds no objective evidence to confirm the complaints, will reach the conclusion there is nothing wrong with the individual. On the other hand, the examining physician for the plaintiff, who, in spite of the fact there are no real, objective findings to verify the complaints, might be inclined to agree with the patient. In these instances the question becomes "Do you, or do you not believe the patient?" This situation should not occur. These cases present a challenge to the examining physician. He should accept the challenge to establish or disprove the medical authenticity of these subjective complaints.

#### PERMANENT DISABILITY

Frequently there is a wide divergence among medical witnesses in estimating permanent disabilities. One reason is the fact that many members of the medical profession who make estimates never have read the chapters on compensation for partial incapacity in the Workmen's Compensation Act. The latest bulletin No. 22, issued October 1, 1953, covers this in section 1314-B. Knowledge of this section does not solve all the problems but at least it will serve as a foundation in evaluating disabilities.

This probably is one field where our own pro-

fession has been somewhat remiss in that no organized medical body has made an attempt to standardize a method of disability evaluation. The question arises whether this standardization should be done on a state or national level. I might point out that a committee from the Eye, Ear, Nose and Throat Section of the Connecticut State Medical Society has formulated a standardized scale for estimating loss in vision and it has proved very satisfactory.

The present applicable literature on this subject illustrates the need for uniform standards in that each author presents his own idea on how to arrive at a percentage of disability. One author takes into consideration seven variables in his determination. Each of these variables is assigned a certain percentage of the normal function. Each variable is estimated accordingly. The more variables there are in estimating a disability, the more chance that differences of opinion will occur among doctors. Therefore, the simplest formula possible is to be desired. A system based solely on an anatomical basis, which of course would cover the functional loss, would be the most practical. In the case of joints, the loss of motion could be measured with a protractor against a normal opposite side and a percentage of disability could be given for the degree of motion lost. This would reduce the problem to a mathematical one and should lead to more uniform opinions.

The part of the body most difficult to evaluate is the back. As far as I could ascertain, no State ascribes a definite value to the back in terms of compensation weeks, nor do any of the authors I have read mention disability evaluation of the back. When we consider that in Connecticut back injuries lead all others, the necessity for something definite on which to base an estimate of disability becomes apparent. At the present time the percentage of loss of the back is estimated on the basis of 780 compensation weeks. This represents the entire body. If the statute assigns certain values to arms and legs, eyes and ears, then there is no reason why a value should not be placed on the back. Repeated attempts have been made in past sessions of the State Legislature to introduce such a clause into the Compensation Act. None of these efforts have succeeded. If a value is to be assigned, the area included must be specified. The back might be defined as from the 1st dorsal vertebra to the coccyx. These limits bring in the lumbosacral junction where most of our back strains occur, and the coccyx which, as everyone knows, presents a rather vexing problem when it is

injured. The cervical region could be assigned a value in compensation weeks to cover discs and fractures and/or dislocations.

The authors who have contributed to the literature on the subject of disability evaluations have advanced carefully thought out methods for the determination of the percentage loss. All differ in one way or another with the result that the final percentages differ. Some of the procedures seemed unnecessarily complicated because practically all states have assigned values to the various parts of the body. The Connecticut law assigns values down to "more than half a phalanx or less than half a phalanx." These illustrations serve to point out the need for a uniform, standardized procedure for disability evaluation. This could best be done at the national level.

The Academy of Orthopedic Surgery has introduced instructional courses in disability evaluation in the last two annual meetings. This is a step in the right direction and it is to be hoped that something may come of it. Another group that could become interested in this field is the Committee on Trauma of The American College of Surgeons.

#### REHABILITATION

A very important phase in the medical care of an injured workman is that of rehabilitation. It should be the aim of the medical profession to return every injured workman to full economic usefulness, or as near to it as is humanly possible. The first step in the rehabilitation program starts at the first visit. It is an accepted fact that a poor initial result will rarely give a good end result. We should make certain that the injured part receives the best accepted treatment of the day. This demands that we should ask ourselves, "Am I capable of treating this patient's particular injury?" If the answer is no, the patient should be referred to one who has had more experience in treatment of this injury.

Another important point in the early rehabilitation of the patient is to make no statement which would allow the patient to believe his condition is more serious than it actually is. Many times while taking a history in chronic back cases, who have been disabled a year or more, the patients have told me that at the first examination by their doctor they were advised they had wrenched every muscle in their backs. One man leaned over my desk, brought his clenched hands together, then twisted them around as if he were wringing out a wet towel. This was to

describe to me what he had done to his back. Other patients have assured me that their first examination showed their backs were "all shot." I have always made it a point to tell these patients that I doubted their doctors made such statements, or that they had misunderstood them. However, the patients insisted the statements were made. Whatever the case, the patients had convinced themselves that they were ruined for life, thus setting up a mental barrier that made rehabilitation almost impossible.

Another factor that predisposes to chronicity in back cases is the substitution of heat instead of rest, either bed rest or immobilization at the initial treatment. There is a good saying to the effect that if a part hurts you, put it at rest. A baking lamp does not do this. When an acute back, like an acute sprained ankle, becomes subacute or chronic because of inadequate immobilization, it is very difficult to effect a cure. One week of absolute bed rest at the start in an acute back case does more good than two months of baking.

Many patients who have an acute back strain are very apprehensive about their condition, more so than any other type of industrial accident. Sprained ankles, on the other hand, no matter how painful, seldom are causes for concern. This apprehension about back injuries goes back to the days when the sacro-iliac strain was the dreaded back condition. The lay people keep abreast of medical progress with the result that today ruptured discs have supplanted sacro-iliac strains as the most serious back injury. If the patients are not worried about a disc, they are certain that some bone is out of place in their backs. This appears to be due to the vogue enjoyed by manipulative practitioners.

After a thorough examination has been made it is advisable to spend a little time explaining to the patient that what has happened to his back is comparable to a sprain of an ankle, namely, that a muscle or ligament has been stretched beyond its normal limit. Frequently such an explanation seems to satisfy the patient. It is unnecessary to bring up the question of a ruptured disc, hypertrophic arthritis, or an anomaly at the lumbosacral junction at the start of the treatment. This will only serve to confuse and worry the patient. This, of course, does not mean we should not be alert to detect any complication or any condition that might have a bearing on the prognosis or treatment.

Another important phase in the rehabilitation is



the aftercare in the office. Once more the doctor should ask himself if he is prepared to give the patient the proper amount of time at each visit. It is not enough to simply expose the part to a baking lamp or diathermy machine. There has been considerable criticism directed toward our profession because of bills of \$300 to \$400 rendered for baking treatments that have not improved the condition treated. If the doctor decides he is not equipped to give proper rehabilitation care then he should refer the patient to a rehabilitation clinic. There is one very important point to remember if the patient is to be referred to a rehabilitation clinic. He must be referred early in the treatment and not wait until the disability is beyond repair. Otherwise, it is not fair to the clinic where the patient has been referred.

Hippocrates is supposed to have said that the desire for a cure on the part of the patient is half the treatment. This is particularly true in rehabilitation. Unfortunately there exists a small minority of injured workmen who are not imbued with the desire for a cure, or at least they will not admit they are cured. This group remains small but like the concern for the one lost sheep we forget about the vast majority who cooperate so diligently to obtain a cure. This minority group realizes there are certain compensation awards for certain permanent disabilities. When a patient becomes legal minded it is practically impossible to effect a cure. These patients usually are troublesome, not only to the doctor but also to their attorneys, because they have exalted ideas about the amounts of money they should receive.

There are a few injured workmen who develop a defeatist attitude toward rehabilitation. They reason that there is no sense in being rehabilitated since they will be unable to resume their old jobs and there is no other work for them. This situation should be remedied. Granting that it is rarely possible to place a physically handicapped person in construction work, there should be a place in every large factory for an employee who has a physical handicap as a result of an injury sustained at work there.

Fortunately injuries resulting in a severe physical handicap are uncommon. Severe crushing injuries to the hand which result in a large percentage of loss are the most common. Many factories, where the accident occurs, have a place for the employee as soon as his wound has healed sufficiently to return to

work. These same factories also provide suitable temporary jobs for injured employees who may not be able to do their regular work because of an injury, but can do a different job during their period of temporary disability. In other factories it is impossible to place an injured workman during his period of temporary disability although, as in the aftercare of a fracture, light exercise of the part is desired. The rule in these factories seems to be that the patient cannot return to work until he is able to do his regular job. I have looked into this matter and have been told these persons cannot transfer to other departments for suitable work because of union seniority rights. If this is a fact, then the unions could render a great service to their members by remedying this situation. Possibly the combined efforts of union and management are necessary to effect this.

After all is said and done on the subject of rehabilitation, one of the very best procedures is to return the injured workman to a gainful occupation during his convalescent period. Daily work not only hastens return of function but improves the patient's morale because he is not suffering the financial loss that compensation payments of 60 per cent of his average weekly wage entails. As far as the truly physically handicapped persons are concerned, if the handicap occurred as the result of an industrial accident, then industry should have a place for these persons. This is not charity, it is their just due. The value of the physically handicapped in industry is being proved daily throughout the nation. They take their places as useful members of the community and as such assume all the obligations that good citizenship requires.

To summarize: Two facts can be emphasized: 1st, the medical profession under the Connecticut Workmen's Compensation Act is in no way limited in the professional care of an injured workman; 2nd, in spite of the constant efforts of industrial safety engineers, and the efforts of the Connecticut Labor Department, with its safety inspection and consulting service and statistical department, showing how and where accidents occur, we still have accidents. From these two facts a conclusion is obvious. With no restrictions imposed on us and with the large number of accidental injuries, the responsibility is ours to return these injured workmen to full economic usefulness, or as near to it as is humanly possible.

## VARIATIONS ON A THEME

ROBERT A. MOORE, M.D., *St. Louis*

SELF evaluation and self improvement have always been, and I hope always will be, an integral part of medicine and of the medical profession. We may well be proud of those men who in 1847 issued the call for an organizing meeting of what became the American Medical Association and stated in the first sentence, "It is believed that a National Convention would be conducive to the elevation of the standard of medical education in the United States." From that day the medical profession through various groups has concerned itself with improving medical education and medical care so that mankind might benefit. With this viewpoint medicine may qualify as a profession in the fullest sense of Judge Pound, "A profession is an organized calling in which men pursue a learned art and are united in the pursuit of it as a public service—no less a public service because they make a livelihood thereby."

Specialization within the profession has brought with it problems and conflicts. The original group to recognize some need for self evaluation in the specialty field was the ophthalmologists. On May 15, 1917 the American Board for Ophthalmic Examinations was incorporated and thus what is now the American Board of Ophthalmology has been in continuous service for 37 years. In the succeeding 16 years there were only three other groups which saw the advantages of self evaluation—the otolaryngologists in 1924, the obstetricians and gynecologists in 1930, and the dermatologists and syphilologists in 1932. The four groups with representatives of the medical schools, federation of state medical boards, the Council of the American Medical Association, the Hospital Association, and the National Board of Medical Examiners held an organizing meeting at the annual convention of the American Medical Association in Milwaukee in 1933 of what is now the Advisory Board for Medical Specialties.

The Advisory Board is thus 21 years old this year and is an adult. With individual human beings the 21st birthday is an important event and it should be also with human institutions. It is a time when full

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## SUMMARY

The origin of the Advisory Board for Medical Specialists is traced. The theme referred to in the title is that a specialty board is a voluntary agency concerned with certification of the competency of professional health personnel in limited fields of practice. Variations of this theme are developed: (1) a specialty board is not an educational agency; (2) it is not the only agency concerned with maintaining and elevating standards; (3) it is not a standardizing agency; (4) a specialty board is not a guild; (5) it is not a licensing agency; (6) it is not an agency concerned with the economic status of medical practice; and (7) a specialty board is not an agency out of the field of medicine and out of touch with the world.

If any one has any doubts as to the proper place of the specialty board, Dr. Moore's exposition should dispel them.

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responsibility is conferred and assumed. The days of hiding behind others and shifting responsibility to others are over. The adult must take his place in society and give leadership to those ideas and principles for which he stands.

As your president on this 21st birthday, I have chosen to speak not as the father lecturing his son, but as the son admonishing himself and enunciating a philosophy. It is also a farewell, as I have spent my twelve years on the Board of Pathology and hence am not eligible for reelection under our Articles of Incorporation and By-Laws. I have both a sense of relief and a feeling of regret. The sense of relief comes in that I shall not have to work 18 hours a day for six days in two periods each year and then go home to make up the lost sleep and reaccumulate adrenalin. The feeling of regret is derived from many sources—the opportunity of close association with



my colleagues, the opportunity to see young men and women come before the board as youngsters and then a few years later hold responsible positions in their professions, and the opportunity to play a small part in the broad program of self evaluation to benefit medical care.

I have chosen as my topic "Variations on a Theme." I am not a musician; in fact, I am tone deaf. But what I wish to discuss with you is analogous to the musical concept of variations on a theme. The theme is that a specialty board is a voluntary agency concerned with certification of the competency of professional health personnel in limited fields of practice. Let me read that again because the remainder of my remarks are just variations on this theme. A specialty board is a voluntary agency concerned with certification of the competency of professional health personnel in limited fields of practice. The essential points or full notes of the theme are "a voluntary agency," "certification of competency," "professional health personnel," and "limited fields of practice."

The first variation on the theme is that a specialty board is not an educational agency. Most boards acknowledge this and so state specifically in their booklets. The usual statement is: "The Board is in no sense an educational institution and the certificates of the Board are not to be considered degrees." Yet, one Board has this statement: "To encourage improvement of educational facilities and clinical training in Xology at undergraduate and graduate levels in medical schools and hospitals." To make sure you heard six words in that quotation let me repeat them together: "At undergraduate levels in medical schools." It is true that the introductory three words are mild—"To encourage improvement"—but just the same here is an outside pressure group in a specialty attempting to influence undergraduate medical education. Let us not forget that we were and are physicians before we were specialists. One of the fundamental defects of medical education today is the teaching of more and more specialties and less and less medicine. We, of all people, should know that a special superstructure must rest on a firm broad foundation. We must support the principles recently formulated by the Association of American Medical Colleges.

Undergraduate medical education must provide a solid foundation for the future physicians' development. It should not aim at presenting the complete detailed systematic body of knowledge concerning

each and every medical and related discipline. Rather, it must provide the setting in which the student can learn fundamental principles applicable to the whole body of medical knowledge, establish habits of reasoned and critical judgment of evidence and experience, and develop an ability to use these principles and judgments in solving problems of health and disease.

Thus, as the kettledrums roll for the end of the first variation, I say let the specialty boards stay out of the field of undergraduate medical education entirely and completely. It is not a proper location of operation for those concerned with and interested in specialties.

The second variation on the theme is that a specialty board is not the only agency which is concerned with maintaining and elevating standards. There are many other groups which are vitally interested and I venture to say may know more about "maintaining and elevating standards" than do the trustees of the specialty boards. I would be the first to defend the thesis that a specialty board must be an independent agency and not be forced to respond to every pressure brought to bear on it from minority groups. We thus have the possibility of two evils—too little and too much.

On the category of too much I would place this statement of one Board. A certificate may be revoked if the diplomate is guilty of violation of the standards of ethical practice and "the expulsion from or suspension from the rights and privileges of membership in the American Medical Association or any state or county medical society affiliated therewith, any recognized Canadian Society, the American Association of Xology, the American Xological Society shall be conclusive evidence of the violation of such standards of ethical practice of medicine."

In my book the American Medical Association and national societies should be and have been a force for good and should be supported. But I fail to see how competency to practice a specialty of medicine is influenced one whit by these memberships unless we assume they are the only source of continuation education and they are not. Again, I have every regard for Boards of Censors and Judicial Councils, but in my concept of democracy action by a self constituted group is not final. There must always be the right of appeal. I much prefer the procedure of another Board which provides for possible revocation of the certificate "if the physician so certified shall violate the standards of ethical practice of

medicine or shall have been convicted by a court of competent jurisdiction of a felony or of any misdemeanor involving, in the opinion of the Board of Directors, moral turpitude in connection with his practice of medicine."

On the score of too little let us not forget the admonition of Arthur Dean Bevan in his first chairman's address of the Council on Medical Education in 1905: "The conclusion was reached that the most effective work could be done by this Council not independently but by cooperating with other agencies which were interested in and working for the elevation of standards of medical education." For the moment, and the moment only, I will acknowledge that the type and quality of graduate medical education is of some concern to the specialty board. One Board expresses this as "To act as advisers to prospective students in Xology." Another states "The American Board of Xology shall encourage the establishment of appropriate educational and training standards and shall determine that candidates for certification receive adequate preparation." Still another has as a chief function of the Board: "To consider and advise as to any course of study and technical training, and to diffuse any information calculated to promote and ensure the fitness of persons desirous of qualifying for a certificate of qualification to be issued thereby."

Strains of the first theme are now intermingled with those of the second. All three of these statements indicate a possible concern with the details of the graduate training. If we approve certain institutions and individuals to provide training, and I suppose we must do this if for nothing more than information, let us not then second guess the man who is responsible for the training. For example, do not provide that the practical examination may include a separate visit to the institution where training was secured, and "inspection of clinical records, reports of departmental activities, library facilities, available apparatus, etc." If these were not satisfactory the residency should never have been approved.

As the violas carry the first variation and the cellos repeat the second variation the trumpet comes forth with the third variation—that a specialty board is not a standardizing agency. One Board expresses this well: "The Board assumes the responsibility for determining the standards of knowledge to be acquired, but upon the candidate rests the responsibility of acquiring the knowledge to fulfill these

standards." Let us not forget that in all education, including graduate medical education, learning is more important than teaching.

On the other hand, another Board states: "The Board is attempting to increase and to standardize the facilities for Xologic training in teaching institutions." I was more than a little shocked to find that my own Board of Pathology states "Its chief aim, as stated above, is to standardize the qualifications for the specialty of pathology . . ." There is a difference between standardization and minimal standards and the two should not be confused.

In many things in the last decade, especially in medical research, the glamour of the project or the system has put the man into the shadow. Progress will end when a group of men, no matter how wise they may be, force all other men into a groove of standardization. We will really be in a rut then—the rut of status quo.

Now with every instrument playing and repeating in full volume—let us emphasize the brain of man even if we have to discard entirely the system. Let us have more of the policy of one Board: "In exceptional circumstances, certain candidates who cannot meet all the above requirements may be accepted for examination, upon recommendation of the Credentials Committee, substantiated by action of the Board;" or of another Board: "In specific instances the Board may waive any part of these requirements with the exception of the item of personal appearance." When I first read this I got the same shock that perhaps some of you did. Well, here it really is. Competence is related to personal appearance—shoes shined, trousers pressed, ears washed. But rereading showed it was that the person is to come before the Board. Only one Board provides that the diplomate whose certificate is in question may appear before the Board, a fundamental part of democracy for which our forefathers fought.

Let us change just one note in this variation and thus bring up a musical picture of what is the fundamental reason for education and training. No one will disagree that the ultimate objective of education and training is the improvement of our society and the development of men and women better able to serve society. Yet, there has grown up in our educational system the idea that I must do this or that or I must learn this or that to satisfy someone else or some group or to pass an examination. How many times have you been told when you asked a



young man why he wanted a residency, "In order to qualify for the Board." Only rarely do we hear, "In order to improve my knowledge of medicine." Graduate medical education and the specialty boards are not the sole offenders here, but each segment of education should do everything it can to change this attitude and philosophy of "why secure an education."

Again let us change another note in this third variation to explore further the man and not his origin. The postwar years have brought to this country many men and women who had their education and training in other lands. There are two aspects of this problem, which can be summarized in one sentence. America, for its own welfare, must remain a land of opportunity; but the quality of medical care must be maintained or even elevated. The quality of medical care is the sum total of the individuals who are rendering it. Thus again we return to the man. Why not approach this problem as one Board: "A candidate trained in a foreign country must be able to give proof of medical and graduate training comparable to the requirements of the Board." Yet this same Board requires that a candidate be a full citizen for three years before admission to examination. We must remember that we of the specialty boards are passing on physicians who already have the right to practice medicine granted by a legally constituted state governmental agency. What then does citizenship for three years have to do with competency. State boards quite properly require citizenship for a license.

I hope the day will come when there will be no requirements for admittance to a board examination except good character, graduation from medical school, a license to practice medicine, and belief by the candidate that he knows enough. And that the examination will become a welcome challenge to the examinee and not an expression of the sadism of the examiner. To attain this objective of the examination we must give increasing attention to improving our examination procedures and not go on year after year with outmoded techniques.

Before leaving this theme may I have all the instruments in crescendo repeat it again—let us emphasize the intellectual capacity of the man even if we must discard entirely the system. America and American medicine have grown and prospered by the originality and ability of men, not by standardization.

And now the strong notes of the bassoon enunciate the fourth variation of the theme—that a specialty board is not a guild. One Board openly disclaims the guild idea with this statement: "This Board has been organized, not to prevent qualified Xologists from obtaining certificates, but to assist them in becoming recognized in their communities as men competent to practice in the special field of Xology." Several other boards even go further; one expresses the idea as follows: "The major object of the Board is to pass judgment on the competence of Xologists who desire certification—not to determine who shall or shall not practice Xology as a specialty." In contrast, another Board states that a function is: "To establish criteria of fitness to be designated a specialist in the practice of Xology." Less bold but also broad is another Board. "The Board has been established primarily to determine the competence of physicians who specialize in Xology."

Several Boards repeat and expand this variation of the theme more exhaustively. Typical is this statement: "The American Board of Xology is not concerned with any mechanism which gains special privilege or specific recognition for those physicians who have been certified in Xology. It has never been the intent of the Board to define requirements for membership on the staffs of hospitals." Another Board goes on to say: "The Board specifically disclaims interest in or recognition of differential emoluments that may be based on certification."

On the other hand, it is clearly stated by several Boards, of which I cite one, that diplomates are given a special mark in the American Medical Directory, but the Board "does not give such special recognition to Diplomates who are not members of the American Medical Association."

Even a more powerful instrument, say the tuba, now sets the fifth variation on the theme—that a specialty board is not a licensing agency. Many boards frankly disclaim this function. One Board puts it plainly: "The certificate does not confer on any person legal qualifications, privileges, or license to practice medicine or the specialty of Xology. The Board does not purport in any way to interfere with or limit the professional activities of any licensed physician."

Yet another Board gives as one of its functions: "To protect the public against irresponsible and unqualified practitioners." This might be interpreted

as just theoretical but a following function puts teeth into it: "To do all things necessary or incidental to the foregoing specified purposes."

A minor deviation of this theme relates to the continuing responsibility of the Board for the competence of its diplomates. One Board provides that a certificate may be revoked if "the physician so certified shall at any time have neglected to maintain the degree of competency in the practice of Xology as set up by the Board and shall refuse to submit to reexamination by the Board." I seriously doubt that Boards can enter into policing the practice of their specialty, which is after all only a part of the practice of medicine. The state boards of medical examiners were established to protect the public in malpractice and dyspractice.

The sixth variation on the theme comes forth when a plaintive note from a woodwind—that a specialty board is not an agency concerned with the economic status of medical practice. No Board publishes this fact but let us face up to the truth that some, at least discussions of eligibility and revocation of certificates in the last few years, have revolved about economics. Unless some action is clearly unethical by general definition, it has no relation to competency. We can not separately set up criteria for the ethical practice of medicine and the ethical practice of a specialty of medicine; it is all the practice of medicine and control of practice is not a proper function of a specialty board.

The seventh and final variation on the theme is—that a specialty board is not an agency out of the field of medicine and out of touch with the world. So far as I can learn only one Board openly espouses this idea in stating its purposes: "The purpose is advancing, elevating, and developing the practice of medicine in the United States of America and else-

where by encouraging, teaching, and elevating that branch of medical practice which deals with Xology." Each person is first, a human being living in a changing world; second, he is a physician; and third, he is a specialist. At least one Board recognizes this in a published statement: "Properly qualified candidates who are permanent residents in and citizens of other countries and are legally qualified to practice medicine there, and who have received their training in Xology in the United States or Canada may apply for certification."

A good composition of variations on a theme at some time returns to the principal theme. To close my composition I do so—that a specialty board is a voluntary agency concerned with certification of competency of professional health personnel in limited fields of practice. One of the major obligations of a voluntary agency is leadership.

In my opinion the specialty boards have made a real contribution to the improvement of medical practice in the United States. They can make even a greater contribution. But, as I have played the variations this morning, there have been discordant notes certainly from the French horn and also from even more reliable instruments. As these discordant notes have been played in the last few years, others, both friends and opponents, have in typical Viennese fashion shuffled their feet.

The conductor of this orchestra is the Advisory Board for Medical Specialties which is 21 years old and an adult. A good and able conductor, especially one of legal age, can eliminate discordant notes and can bring balance and harmony into a composition which fits into the thinking of the people and from which everyone derives satisfaction and benefit. I urge the Advisory Board to seize the conductor's baton and lead.



## SURGICAL APPROACH TO CORONARY ARTERY DISEASE

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### INTRODUCTION

This presentation concerns our work on the coronary artery problem. It is based upon 4,000 to 5,000 experimental operations on dogs. It is also based upon operations on 192 human patients with coronary artery disease. The direct approach to the coronary arteries and veins was used in this work. This direct approach is emphasized because it yielded information that could not be obtained by any other method. Various experimental procedures were carried out on the heart and the results of these were observed. In order to accept the results of the experiments it was necessary for us to change any preconceived ideas that stood in the way of acceptance. In other words, it was necessary for us to change our attitude in accordance with the observations. Our attitude towards coronary artery occlusion, therefore, is based upon facts that were established by experiment.

### METHODS OF STUDY

Two methods of study were used:

(1) Coronary Artery-Ligation-Mortality-Infarct Method.

This method was used early and extensively in our work. It was evolved in our laboratory. It consists in placing a ligature around a major coronary artery in order to produce total coronary occlusion. The artery used was either the descending ramus or the circumflex ramus of the left coronary artery or the right coronary artery. As soon as the ligature is tied two statistical studies are carried out. One concerns mortality and the other concerns the size of the infarct in those dogs that live long enough to develop an infarct. Statistical studies are obtained on mortality and size of infarct in normal control dogs using the same test artery. Similar studies are obtained in dogs in which a procedure under investigation was applied to the heart at some previous time. The interval of time between the procedure

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### SUMMARY

The coronary artery problem has been under investigation by Beck and his associates for the past 25 years. Several important facts have been established by this investigation. It has been shown beyond any doubt that operative methods can aid a crippled coronary circulation. It has been shown that by supplying a small amount of blood to an ischemic area of myocardium the mortality was reduced after a major test artery was ligated. This small quantity of blood also preserved the viability of the heart muscle. These facts have been applied to human patients. The transfer from the laboratory to the patient has been made in an orderly and scientific fashion. The results obtained on patients support the laboratory studies. About four out of five patients get a good or excellent result following operation. Operation cannot stop the occlusive disease in the arteries nor can it undo degenerative changes in the muscle. Operation can aid the heart to withstand the next occlusion. It can relieve symptoms and it can restore vigor and energy to the patient.

under investigation and the ligation of the test artery is determined by the experimenter. The dogs are kept several months in order to obtain both early and late mortality. The size of the infarct was determined by making cross sections of the heart at various levels and observing and measuring the size of the infarct. It was readily possible to determine whether the infarct was grossly absent, small, medium, or large.

This test gave us important information. However, it must be carried out properly, otherwise it will have little or no value. A number of variables are present in this test. One variable is based upon

certain differences in the coronary circulation itself in normal dogs. The communications between one coronary artery and another are variable. In order to take care of this factor it is necessary to apply the test to a sufficiently large number of dogs. There are other variables in the test. These are as follows: the general health of the dog, the absence of distemper and other diseases, the nutritional condition of the dog, the size of the dog, the anesthesia, the surgical technique, the placement of the ligature in reference to any branches that might be missed coming off the artery ligated, the completeness of the occlusion, postoperative care, etc. These variables must be taken care of in the best possible manner.

#### (2) Mautz-Gregg Backflow Method.

This method is carried out as follows: The circumflex ramus of the left coronary artery is dissected out. This artery is ligated proximally. The artery is cut distal to the ligature and measurements are made on the backflow from this severed artery. The amount of backflow is measured as is also the oxygen content of the blood. This method of study has yielded important information and has been used extensively by my associates, Richard Eckstein and David S. Leighninger.

#### COMMENT ON THE CORONARY CIRCULATION—ITS VULNERABILITY

The coronary arteries carry more blood to the heart than is necessary for normal function. The correctness of this statement is indicated by the severe reductions in the lumina of the coronary vessels as sometimes found at autopsy examination. In some of these specimens the lumen of the arteries is greatly reduced or completely occluded. These reductions may be so severe that one wonders how the heart received enough blood to keep on beating as it did up to the time of death. Experimentally Richard Hahn and I were able to produce severe occlusions of the coronary arteries in dogs. Indeed we were able to occlude all coronary arteries except the septal artery. We were also able to occlude all coronary arteries including the septal artery with the exception of a lumen of 1.0 to 1.5 mm. in the circumflex artery. These dogs were strong and active after these occlusions were produced. The heart beat can be maintained in the presence of severe and extensive coronary artery occlusion. I cannot give any figures in terms of bloodflow to indicate how much the inflow can be reduced and still maintain the heart beat but I estimate that the inflow can be

reduced by as much as 90 per cent of the total normal inflow. To accomplish this the occlusions must be carried out in stages and no one occlusion can be too abrupt. In order to accomplish this it is also necessary that the coronary arteries communicate one with another by intercoronary channels so that the danger of unequal distribution is avoided.

In many human patients the occlusive process in the arteries is brought to a halt by death before the occlusion becomes complete or extensive. Thus Yater found that the specimens in one-third of all victims of coronary artery disease showed no myocardial infarcts, either old or recent. The coronary artery system has an Achilles' heel. This vulnerable aspect of the coronary circulation is brought about by an ischemic area in the heart muscle. An ischemic area may destroy the coordinated mechanism of the heart beat and replace it by ventricular fibrillation or asystole.

I applied the term "trigger mechanism" to this type of death. In this condition the cause of death is not due to a severe reduction in total inflow but rather to an uneven distribution of the blood that enters the coronary arteries.

#### MUSCLE DEATH VERSUS MECHANISM DEATH

These terms were introduced by my associate, Herman Hellerstein. They are self explanatory. Mechanism death is one in which the mechanism is destroyed. The normal coordinated mechanism is replaced by ventricular fibrillation or ventricular asystole. The heart is capable of continued function. In some instances the muscle is not severely damaged and it may be normal. The arteries may not be extensively occluded and they may be normal or almost normal. In other instances the arteries are occluded and one or more infarcts may be present but the heart is not severely damaged and is capable of continued function. These people die at any time and under a large variety of circumstances. Death may occur at rest, after a meal, shoveling snow, watching an athletic contest, etc. These deaths offer a challenge to the medical profession. In my opinion this is an important problem in medicine. It is important because it kills a large segment of our population each year. It is important because, in my opinion, something helpful can be done to prevent it. Experimentally the heart can be protected against mechanism death. We have shown this to be a fact. It will be necessary to accept this fact and after it is accepted it will be reasonable to consider application



thereof to human beings. Several steps are necessary for this new era in coronary artery disease to evolve. First, the problem needs definition. It should be recognized that we are dealing with a type of death which occurs about as frequently as did death from pneumonia before the advent of sulfa drugs and the antibiotics. We must recognize that death occurs in people whose hearts are capable of continued function. These deaths are similar to those that occur in the operating room and surgeons are learning to resuscitate these patients with good hearts. Courses in resuscitation are being set up in some medical centers. These mechanism deaths make me think of the act of turning off the ignition switch in a motor car and throwing away the key. If the reader accepts the fact that mechanism death can be prevented in the experimental laboratory, then the next reasonable step is to apply this protection to those people who need this protection.

#### WHAT SURGICAL METHODS CANNOT ACCOMPLISH, AND WHAT SURGICAL METHODS CAN ACCOMPLISH

In order to understand what can be accomplished by surgical operation it is important to understand what cannot be accomplished by operation. It is scarcely necessary to state that surgical operation cannot stop the occlusive process of the coronary arteries. It is also scarcely necessary to state that surgical operation cannot restore the degenerated myocardium. Surgical operation cannot give the heart a new system of coronary arteries. What it can do, however, is to supply a crutch to a crippled coronary circulation. It can provide a small amount of blood (6 to 8 cc. per minute) to an ischemic area of heart muscle. This blood reduces mortality and helps to preserve the viability of heart muscle after a major coronary artery is ligated.

#### METHODS BY WHICH THE BLOOD SUPPLY TO THE HEART CAN BE IMPROVED

There are two methods for improving the blood supply to the heart. One of these is by the production of a more uniform distribution of the blood that goes through the coronary arteries. An English surgeon, Mr. Michael Wilson, who spent the past year in our experimental laboratory, stated it well when he said it is a matter of "rationing the blood in short supply." This can be accomplished by surgical operation. The other method for improving the circulation is by the addition of blood to the myocardium. We studied two methods for additional blood. One consisted in placing grafts upon the heart

in the expectation that blood would flow across from the graft to the heart. We used various grafts, as follows: parietal pericardium, mediastinal fat, internal mammary artery with substernal muscle, lung, chest wall, skin, omentum, spleen, and bowel. We have had a certain amount of success with these methods. We have specimens in which anatomical communications are present between graft and heart but we have no flow measurements. We expect to make pedicle grafts which can be clamped off and then opened up so that measurements can be made by the Mautz-Gregg method of backflow. Measured by the coronary artery ligation-mortality-infarct method these grafts are beneficial. However, in these experiments the protection due to intercoronary flow was not separated from any possible flow from the grafts. Almost any operative procedure on the heart produces some intercoronary communications. Leighninger and Eckstein have shown that sham operations produce intercoronary channels and that these carry enough blood to be protective.

Another method for adding blood to the heart is by way of the venous system in the heart. Red blood was delivered to the coronary sinus system of veins by placing a vein graft between aorta and coronary sinus. This aspect of the problem has been studied for the past eight years in our laboratory. This work was done by Drs. Stanton, Batiuchok, Leiter, McAllister, Leighninger, Hahn, Kim, Dalem, and Wilson. Eckstein in his own laboratory has made important contributions on backflow measurements in dogs in which we had performed this operation. It was shown that blood flowed from the venous system through the capillary bed in a backward direction. It was shown that this blood gave up its oxygen and emerged from a cut artery as reduced venous blood. It was shown that this additional blood from the aorta afforded good protection to the heart after ligation of a test artery. Protection was afforded in two ways by this method. One was by the addition of blood to the heart through the graft from the aorta. This additional blood entered the heart for six to eight weeks. Then this backward flow stopped, due to intimal thickening of the veins. In the dog flow from this source ceased completely. Whether this occurs in human patients cannot be stated at the present time. While backflow from this source was decreasing after the graft was placed, another source of backflow appeared. This backflow came from intercoronary channels and these channels afforded significant protection after

test ligation of a coronary artery. This protection was present after a year and we assume it to be permanent.

There are other possibilities for improving a crippled coronary circulation which at present are not applicable. One of them is the replacement of a diseased segment of coronary artery by graft. Another is the removal of atheromatous and calcified deposits in the walls of the coronary arteries. Another is to graft a systemic vessel to a coronary artery beyond an occlusion. These ideas are not practical because the diseased coronary arteries cannot be manipulated at operation without fibrillating the heart. If the heart could be put at rest by any of the methods now being developed, it might be possible to do operative procedures on the coronary arteries themselves without inducing fibrillation.

A foundation in fact has been laid for surgical operation in the treatment of coronary artery disease. Operation can protect the life of a dog if it is done before a major coronary artery is occluded. Operation also can reduce the size of the infarct after a major coronary artery is occluded. Two operations have been measured in our laboratory and we know what they can accomplish. Several other operative procedures have been described by various surgeons. These procedures should be measured so that their accomplishments will be known. Methods for measurement exist and these measurements should be a prerequisite to application to patients. Emphasis is placed upon these scientific measurements. After all such measurements have been made then the most effective procedures can be selected and incorporated into the best operation for the patient. Without these measurements there is no satisfactory way to determine what any given procedure will accomplish.

TWO OPERATIONS

Two operations were developed in my laboratory. My associates refer to these as the Beck I Operation and the Beck II Operation. The number I operation consists of the following procedures: abrasion of the epicardium and the lining of the parietal pericardium, application of an inflammatory agent to these surfaces in the form of powdered asbestos (0.2 Gm.), partial ligation of the coronary sinus and the grafting of mediastinal fat and parietal pericardium to the surface of the heart. Each of these procedures has been studied and measured. Grouped together as an operation they protect the heart primarily by the

development of intercoronary and extracoronary arterial communications. We do not have flow studies on the extracoronary communications from the grafts and we cannot make a statement concerning their importance relative to the intercoronary communications. The number II operation consists of diverting red blood from the aorta into the coronary sinus and its tributaries. This is accomplished by placing a short vein graft between the aorta and the coronary sinus. This establishes a fistula. Two to three weeks later the fistula effect is reduced by placing a ligature around the coronary sinus where it enters the right auricle and occluding it to a lumen of about 3 mm. This operation protects the heart by diverting blood from the aorta to the heart muscle. It also protects the heart by the development of intercoronary arterial channels. As stated elsewhere, the retrograde flow from the aorta stops after six weeks and the protection thereafter is due entirely or almost entirely to intercoronary arterial communications.

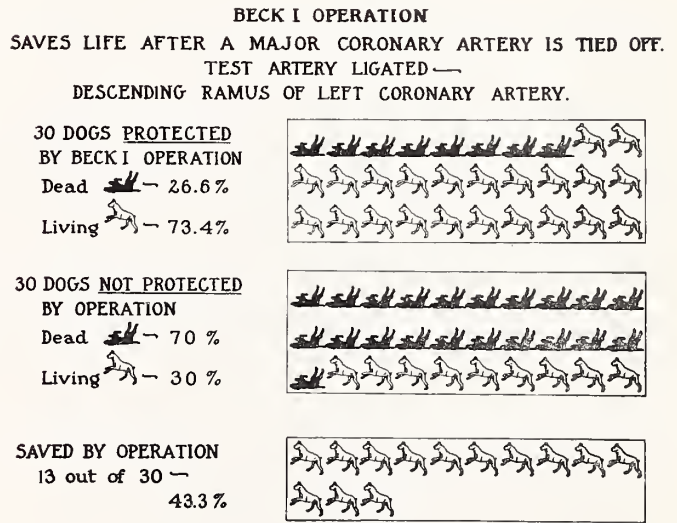




TABLE I

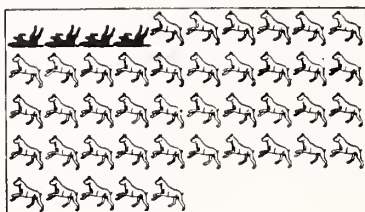
The amount of protection provided by these two operations is shown in Tables I and II. The number II operation affords greater protection than does the number I operation. These tests on the number II operation were done about three weeks after the second stage of the operation was completed, and the protection at this period is due to backflow from both the aorta and the other nonoccluded coronary arteries. The size of the infarct was determined in these hearts that recovered from the test artery occlusion. In the number I operation the infarct was reduced by 60 to 70 per cent and in the number II





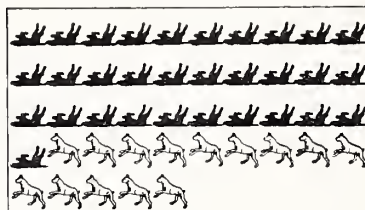
## BECK II OPERATION

SAVES LIFE AFTER A MAJOR CORONARY ARTERY IS TIED OFF.  
TEST ARTERY LIGATED —  
DESCENDING RAMUS OF LEFT CORONARY ARTERY.

45 DOGS PROTECTED  
BY BECK II OPERATION  
Dead  — 8.9%  
Living  — 91.1%



45 DOGS NOT PROTECTED  
BY OPERATION  
Dead  — 70%  
Living  — 30%



SAVED BY OPERATION  
27 out of 45 —  
60%





TABLE II

operation the infarct was reduced by 80 to 90 per cent.

Backflow measurements on the number I operation showed an average of 8.9 cc. per minute. After the number II operation the backflow measurement gave an average of 13.7 cc. The median backflow on 41 normal dogs (Eckstein) was 2.8 cc. If we subtract the median normal from the above the figures the number I operation increased backflow by 6.1 cc. (8.9-2.8) and the number II operation increased backflow by 10.9 cc. (13.7-2.8). The assumption is

TRIGGER MECHANISM KILLS A LARGE SEGMENT  
OF POPULATION.



IT IS ACTIVATED BY ANOXIA. Measurements. (Eckstein)  
CIRCUMFLEX ARTERY LIGATION — death in 1 hour.

20 NORMAL DOGS  
Dead  14 — 70%  
Living  6 — 30%



CIRCUMFLEX ARTERY LIGATION — death in 1 hour.

RED BLOOD DELIVERED TO CORONARY SINUS AT PRESSURE  
OF 50mm.Hg. INCREASES BACKFLOW BY 4cc. PER MINUTE  
FROM 2.8cc. NORMAL TO 6.8cc. AVERAGE IN 14 DOGS.

20 DOGS  
Dead  0 — 0%  
Living  20 — 100%



ISCHEMIC AREA — CIRCUMFLEX LIGATION — IS 50% LEFT VENTRICLE  
DEACTIVATED BY 4cc. BLOOD PER MINUTE.  
SMALLER ISCHEMIC AREAS ARE  
DEACTIVATED BY DROPS OR 1 OR 2cc. BLOOD PER MINUTE.

TABLE III

made that these figures account for the reduction in mortality and the reduction in muscle destruction after ligation of a test artery. Considerable protection is afforded by several cc. of blood per minute.

As further evidence concerning the importance of a small amount of blood delivered to a critical area of myocardium, I should like to present Table III. This table is self explanatory. It shows that 4 cc. of blood per minute delivered to that large area of myocardium supplied by the circumflex artery produces measurable protection. The muscle mass supplied by the circumflex artery is about one-half of the entire left ventricle. Inasmuch as 4 cc. per minute deactivates such a large ischemic area, it is reasonable to assume that smaller quantities would effectively deactivate smaller ischemic areas. It is thus possible to consider drops or one or two cc. per minute as being beneficial to a small ischemic area of myocardium. These experiments again emphasize the importance of small quantities of blood to critical areas in the heart.

Another aspect of the work brought out by the experiments concerns the adaptation of the coronary circulation after the heart recovers from the crisis of a major coronary artery occlusion. We have carried out studies on dogs that recovered from circumflex artery occlusion. These backflow studies were made on the circumflex artery one day, two days, three days, etc., after the artery was tied off. On the first day the backflow was 10.8 cc., second day, 42.0 cc., third day, 68.0 cc., sixth day, 20.0 cc. The backflow in 24 dogs obtained one day to four months after the artery was ligated showed an average of 62.0 cc. per minute (Leighninger). When the circumflex artery is ligated in a normal dog the mortality is 90 per cent. If the heart is protected by the number II operation the mortality from ligation of this artery is 45 per cent (Leighninger and Dalem). The operation helps to carry the dog over the crisis of the occlusion and then after a period of time the coronary circulation recovers to a great extent and the net result is a good coronary circulation and a good myocardium after a major coronary artery occlusion. The operation plays an important part in carrying the dog over the crisis and the final result is an excellent heart.

## SELECTION OF PATIENTS FOR OPERATION

The most desirable patient for operation is an individual who has had the disease for a year or more, who has had one or more infarcts, who is still

able to get around and do some work, who is lean and not obese, and who has some coronary pain. We allow a period of six months to elapse between the last infarct and operation. This is done so that the heart will develop intercoronary channels spontaneously following the occlusion and also for his disease to level off as much as possible. The contraindication to operation is a large, failing heart. In these patients the myocardium is extensively damaged and there is little hope of repairing it. Also these patients are going to die in the not too distant future and it is preferable not to have this occur during or immediately after operation. A number of patients have died in the hospital while the studies were being made prior to operation, and we would have accepted these patients for operation. We have operated on some patients in the 20's and in the 30's. In this young age group it is our opinion that the disease may be rapidly progressive, in which event the risk is greater during operation and immediately thereafter. We have accepted patients who are in status anginosus. We have also accepted patients with some mild enlargement of the heart and in a number of instances we have found an aneurysm at operation. It is scarcely necessary to state that operation will not restore damaged myocardium.

#### RESULTS OF OPERATION

In evaluating the result of operation in patients certain variables are present which should be considered. These variables concern the occlusive process in the arteries and also the development of intercoronary arterial communications. Occlusion of a major coronary artery stimulates the development of intercoronary arterial communications. This occurs in the dog and in the human patient. In the dog these develop in a period of days or weeks. In the human patient a period of six months was placed between occlusion and operation so that these communications would have developed prior to operation. After this period of time the patient may follow one of three courses. There may be some further development of intercoronary arterial channels without operation. In this event the improvement after operation cannot be separated from the improvement which might have occurred without operation. The second possible course is for the occlusive process and for the clinical condition to remain static. In this event it is possible to compare the condition before operation with the condition after operation and determine the effect of the operation. The third possible course is for the occlusive

process to become more severe. In this event the effect of the operation cannot be measured. For illustration let us assume that operation helped the patient by 50 undefined points. Now the patient is better. Another arterial occlusion occurs and makes the patient worse by 65 points. The patient now has a deficit of 15 points; he is worse than he was before operation. Nevertheless the patient might not have been able to tolerate a loss of 65 points. On the basis of these assumptions the patient is worse off than before operation, yet the operation saved his life. It should not be assumed that operation will stop the occlusive process in the arteries. It should not be assumed that the patient will be free of further heart attacks after operation, nor should it be assumed that the patient will not die of coronary occlusion. Operation cannot remove these possibilities. It is reasonable to expect the operation to ameliorate the effects of repeated occlusions. In this event the death may be due to myocardial failure rather than to disturbance of mechanism. For the patient this means extension of life.

The clinical results have not been disappointing. They are as good as I would expect them to be on the basis of the experimental work. For the Beck I Operation 36.3 per cent of the patients stated they had no pain after operation; 48.5 per cent stated they had less pain after operation. This is a total of 84.8 per cent; 27.2 per cent of the patients stated they were better able to work without any limitations and 51.4 per cent of the patients stated they were able to work with some limitations, for a total of 78.6 per cent. For the Beck II Operation 39.6 per cent of the patients stated they had no pain after operation; 48.8 per cent stated they had less pain after operation. This is a total of 88.4 per cent; 41.9 per cent of the patients stated they were better able to work without any limitations and 37.2 per cent of the patients stated they were able to work with some limitations, for a total of 79.1 per cent. Approximately four out of five patients are able to return to work feeling very much better. It is almost necessary to talk with these patients in order to realize the full extent of improvement.

It may be possible later on to find out whether operation prolongs the life of the patient. We have shown that it accomplishes this in the experimental laboratory but we will not be able to demonstrate this so readily on patients because similar groups with operation and without operation will be necessary for comparisons to be made. However, this



study in the future no doubt will yield important information.

The mortality figures in the period 1951 to 1953 inclusive (108 human patients) are as follows: thoracotomy alone 2.8 per cent, Beck I Operation 7.5 per cent, Beck II Operation 26.1 per cent. The two stage operation is more difficult to do. It requires two stages and it carries a higher mortality. However, the experimental measurements of benefit are greater than in the number I operation. Since January 1, 1954 a total of 31 operations were done. The mortality was 1 from thoracotomy alone, 1 for the number I operation and 0 for the number II operation. At the present time preference is given to the number I operation.

#### CONCLUSIONS

1. A large segment of population dies from a dis-

turbance to the normal mechanism of the heart. The underlying pathology in the heart may be slight or moderate in degree. This important problem needs definition. Something can be done to prevent mechanism death.

2. Surgical operation can save the life of a dog after a major coronary artery is tied off, provided the operation is done before the artery is tied. Operation can also reduce the size of the infarct after a major artery is occluded.

3. Two operations were developed. These operations were measured for protection. Backflow studies were also carried out.

4. These operations were applied to human patients with coronary artery disease. The results so far show that about four out of five received a good or excellent result following operation.

## OPPORTUNITIES FOR THE AGED — PAST AND FUTURE

IRA HISCOCK, SC.D., *New Haven*

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The Author. *Professor of Public Health, Yale University*

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### SUMMARY

The problem of the aged and of the chronically ill calls for cooperative joint action by all concerned in Connecticut. The most crucial factors today in this problem are the needs for employment; economic security; medical, dental and nursing care; recreational and spiritual resources; and special housing with proper living arrangements. There is a need for concerted action by the medical profession with the community agencies to combat the growing problem of chronic illness. Health measures in the President's message to Congress, January 18, 1954, are listed.

In the future, as the numbers of older people increase, there will be an anticipated increase in the

demands for physicians' services, hospital care, and nursing services both in the home and in the hospital. Exploration of alternatives to institutional care is needed. The outlook for a better life for these older people in Connecticut is good.

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### OPPORTUNITIES OF THE CONFERENCE

Recent pictures of this field in Connecticut remind us of an unprecedented increase of older people in our population offering a dramatic opportunity "to integrate this 'new generation' into our social and cultural life." How nearly adequate are our existing services and facilities to meet the needs of the 13,000,000 persons in the United States who are sixty-five years of age and over, and the estimated 400,000 being added each year? Who set the age sixty-five as the dividing line? When was the figure

*Presented at the Conference on the Problems of Aging, arranged by the Connecticut Health League, State Veterans' Home and Hospital, Rocky Hill, Connecticut, April 7, 1954*

adopted and by whom? This is a country where so much is offered in some states for enriching the years, and where age is no barrier, according to covers of state annual reports in New York, for example, and where men and women over sixty-five think and feel as others do, according to a comprehensive report from Rhode Island, another neighbor.

Is there a chance of survival from the chronic crisis which is now experienced in America? President Helen McAfee Horton, formerly of Wellesley and the WAVES and now of the National Social Welfare Assembly, said yes in no uncertain terms on last Friday in New York. But while we all have privileges, we have responsibilities in all age and economic and social groups and neighborhoods.

Who are the aged? What are their potentials? Are there approaches to an old problem which we can explore and come up with some practical answers without recommending merely that another study be conducted or another committee be formed? Or, if we do find it necessary to conduct additional studies by new committees, must we start "from scratch" or can we build on present foundations here which are the result of previous conferences, of numerous earlier studies and even of reports of State Commissions of services in several committees, and of experience and studies elsewhere?

Surely coordinated review and planning should lead to cooperative joint action by all concerned in our enlightened, industrial, and relatively healthy and wealthy State community of two million people who are blessed with unsurpassed facilities for communication, education and professional care. Now approaching so-called old age, and having lived for various lengths of time in different parts of the world, Connecticut appeals to me as a satisfactory place to choose "If I Were Unborn" and could choose! But this statement is made with the provision that complicating and selfish vested interests, as well as complacency be reduced considerably and that visibility of programs of activity be increased for the attainment of the great common purpose. It is in this spirit that we all enter this conference which should be a milestone.

#### THE OBJECTIVE

Older people can lead more satisfying lives with meaning for them and their families, despite physical and psychological limitations, if the community provides essential economic and social opportunities. This is not unrelated even to America's need to do

much to help preserve peace and to enhance prosperity and happiness, all of which are interrelated factors in our complex social structure. Most crucial are the needs for employment; economic security; medical, dental and nursing care; recreational and spiritual resources; and special housing with proper living arrangements.<sup>1</sup>

Speaking at the National Health Forum of the National Health Council recently, Dr. Detlev W. Bronk, president of the Rockefeller Institute for Medical Research, called for a campaign against the still wide areas of ignorance to achieve the great new age of man. He deplored the sordid search for security which keeps mankind from the pinnacle of achievement. And at the same time President Eisenhower asserted that progress toward improved health of America would "surely result" from a partnership of the professions. Such a growing partnership is responsible for this conference in Connecticut, with the physician a key person in line with statesmanship exhibited over the years by the Connecticut State Medical Society, as well as by the numerous other voluntary and official agencies charged with increasingly recognized responsibilities for attention to the health and welfare of older, as well as younger people in the Nutmeg State.

It is important to remember, with Dr. Bronk, that in these times of stress and uncertainty, fear for the future grips many thoughtful men and women; but that this "fear and lack of hope" may be, and doubtless is, a temporary consequence of our changing scene. Weary, bewildered men covet security forgetting that in security there is stagnation, decline, and atrophy of the spirit which discriminates man from beast; and in change is true growth and hope." Hence, in this exciting atomic age, increasing attention is being given to human and relative values, for the hope and welfare of mankind.

Meanwhile, with special reference to health affairs, the National Conference on Care of the Long-Term Patient, meeting recently in Chicago, urged concerted action by the medical profession with the community agencies to combat the growing problem of chronic illness, with the onset insidious and the course long, and with families drained emotionally and economically, coupled with the need for continuing investigation of causes and methods of care with the same enthusiasm and financial support as are presently applied to other areas of scientific endeavor.



## THE SITUATION

Concerning employment, the proportion of self-employed in both industry and agriculture is higher at the older ages than at the younger. At the same time, many people who continue in employment in their later years are able wisely to reduce their activity to part-time work.

But the Metropolitan Life Insurance Company finds that fully three-fifths of the men at ages sixty-five to sixty-nine are still employed, with nearly two-fifths at ages seventy to seventy-four, dropping to one-fifth at ages seventy-five and over. For women, the corresponding proportions are smaller. The influence of economic need in keeping older people at work is considerable; all through the older ages the proportion working is higher for married men than for single men, but many women who remain unmarried have to support themselves. "The increase in the chances of survival to the older ages has brought into sharp focus the social and economic problems of the elders in our population. Although the average age at retirement, according to Social Security records, is about sixty-nine, people who reach that age still have an expectation of life of about twelve years. To make adequate provision for this period calls for a program of savings and careful planning during the productive years."<sup>2</sup>

As emphasized not long ago by Surgeon General Leonard A. Scheele,<sup>3</sup> health is at the heart of every aspect of aging. The burden of ill health among the elderly has increased in volume, and will continue. Older people get sick more often and their illnesses are more frequently disabling and last longer. Chronic "degenerative" diseases occur four times as frequently among the old-age group as in the general population. Long-term illness, disabling thirty days or longer, occurs twice as frequently among the elderly, and the average period of disability due to chronic illness is more than four times as long for the older person as for the average person in the general population.

Historically, if we accept the Biblical story of creation, then aging in man, according to an *Indiana Bulletin*,<sup>4</sup> began in Eden and every man and woman since Adam and Eve has experienced the symptoms of aging in greater or lesser degree. The medical problems connected with the process of aging and aging people are listed as three as follows:

1. To maintain the best possible state of good health;

2. To maintain the highest possible degree of physical activity and efficiency;

3. To maintain mental alertness, poise and judgment.

The President's January 18, 1954 message to Congress on the Nation's health problems embraced several measures to improve the health of the American people, giving special attention to problems related to age distribution as for example:

1. Medical Care—Reinsurance for special additional risks involved in broader protection;

2. Rehabilitation, having in mind 2,000,000 disabled persons who could be rehabilitated and returned to productive work;

3. Construction of medical facilities, with federal grants based on a State's population and per capita income. For Connecticut, for example, the need is apparent to give increased attention to the health of older people in homes for the aged and in nursing homes. Resources are too limited for medical and health services properly organized generally, for mental health services, for facilities for care of the sick and disabled, for prevention and care of accidents in the home and on the street, for homes for the aged, and for non institutional living arrangements.<sup>5</sup>

## THE FUTURE

Simultaneously with the future anticipated increase in numbers of older people we should expect increased demands for physicians' services (especially those of the general practitioner), hospital care, and nursing services both in home and in hospital. There may be expected concentration of services on chronic diseases. Nationally, the rate of admissions for persons over sixty-five in State mental hospitals, for example, has increased from 148 per 100,000 in 1933 to 225 in 1948. Mental diseases of old age account for about twenty-seven per cent of first admissions and for eleven per cent of all resident patients. Of patients who have been in the hospital from one to four years, twenty-one per cent have been admitted for diseases of old age. New York estimates that two per cent of its entire older population is resident in mental hospitals. Consequently, future planning must embrace a consideration of many factors.

Our State and local health and welfare agencies have a background of experience.<sup>6</sup> We are inclined to rely upon self discipline and cooperation with

State and local governments to give standards of medical, dental, nursing, educational, legal, and other professional services. Currently, the National Social Welfare Assembly located in New York City and its Committee on the Aging are developing suggestions in the best traditions of country and state. Much attention is being given to the problem also by Councils of Churches, having in mind that religion is concerned with human fulfillment.<sup>7</sup>

Much additional fact finding remains to be done including the development of alternatives to institutional care. Exploration might be fruitful of preventive factors and of alternatives and values to be found in apartment projects, group homes, residence clubs, foster home care plans, home medical care programs, and other arrangements for older people outside institutions.

To quote Surgeon General Scheele speaking in a somewhat similar position before representatives of a group of States recently:

"We need not have high proportions of the older people in institutions bedfast, dependent, mentally confused—and leading a worse than vegetable existence. Their care need not be such a heavy task, physically; and such a discouraging task, spiritually! The place to begin better care for better health (and happiness) is here—at conferences like this—and in our States and committees, in their health and welfare programs, and in the work of public and private institutions." Opportunities for constructive leadership and service are open. May the future for many be better and brighter from our Connecticut deliberations on rehabilitation, chronic illness, health maintenance, education, recreation, employment and retirement in the light of modern views on problems of the aging. May Connecticut's interest be implemented in terms of human and relative values.

In these days of complexity, stress, broadened horizons, and opportunity, people benefit from continuing appraisal of needs and resources and from cooperative action which are fostered through State

and local facilities, as well as National, such as the Connecticut Health League which helps to develop mutual understanding and progress toward more adequate and coordinated community health and welfare programs.

Considerable alteration in individual and community agency operations may be required, or a major operation, but in the words of a brilliant and active thoughtful secretary of a dear friend in Japan, "Please take your heart at ease, since the surgeon says that he is progressing favorably after the operation." The prognosis is promising for a better life for the older people, our family members, our friends and neighbors, ourselves, in Connecticut.

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## SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

## Litchfield, Tuesday, October 5

TORRINGTON COUNTRY CLUB, GOSHEN

Social hour: 6:30 P. M.

Dinner 7:00 P. M.

Business meeting: 8:00 P. M.

*Speaker:* Mr. Philip Staats*Subject:* ADVENTURE IN AFRICA

## Fairfield, Wednesday, October 6

RIDGEWOOD COUNTRY CLUB, DANBURY

Business meeting: 4:30 P. M.

Dinner 7:00 P. M.

*Speaker:* Mr. Rex Stout, Mystery Writer*Subject:* THE PHYSICIAN IN MYSTERY WRITING

## New London, Thursday, October 7

UNCAS-ON-THE THAMES, NORWICH

Business meeting: 4:30 P. M.

Dinner 7:00 P. M.

*Speaker:* Arthur Thibodeau, M.D., Professor of Orthopedics, Tufts Medical School*Subject:* LOW BACK PAIN WITH EVALUATION OF THE PRESENT STATUS OF ACTH AND CORTISONE IN ORTHOPEDICS

## Middlesex, Thursday, October 14

RESTLAND FARMS, NORTHEFORD

Business meeting: 4:30 P. M.

Social Hour and Dinner: 6:30 P. M.

*Speaker:* D. Olan Meeker, M.D.*Subject:* MEDICAL LEGISLATION

## Tolland, Tuesday, October 19

OLD HOMESTEAD INN, SOMERS

Dinner: 6:30 P. M.

Speaker and subject to be announced

## Windham, Thursday, October 21

NATCHAUG CONVALESCENT HOSPITAL, WILLIMANTIC

Dinner: 7:00 P. M.

Business meeting: 8:00 P. M.

Speaker and subject to be announced

## Hartford, Tuesday, October 26

MANCHESTER COUNTRY CLUB, MANCHESTER

Golf: 12:00 P. M.

Business meeting: 4:30 P. M.

Social hour: 6:30 P. M.

Dinner 7:00 P. M.

*Speaker:* Richard Ford, M.D., Medical Examiner of Suffolk County*Subject:* PROBLEMS OF THE PATHOLOGY OF INJURY

## New Haven, Thursday, October 28

THE 1711 INN, MERIDEN

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker and subject to be announced

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The Eighty-Third Congress

A review of the accomplishments of the 83rd Congress should be quite satisfying to the medical profession. Two proposals sponsored by the Administration and opposed by the American Medical Association were defeated, viz., the reinsurance bills and the clause in the social security extension bill including physicians under compulsory coverage. On the other hand the Bricker Amendment to the Constitution was rejected even though our spokesman before the Senate committee made it very plain that its passage would be of material aid in preventing certain treaty entanglements affecting the practice of medicine.

Out of a total of 16,470 bills and resolutions introduced, there were 407 measures of medical interest. The following became public law by approval of Congress and the signature of the President: Fireworks ban; Transfer of Indian hospitals to Public Health Service; Creating Commission on Organization of Executive Branch; Hospital Construction Act amendments; Establishment of Department of Health, Education, and Welfare; Establishing Commission on Intergovernmental Relations; Western States compact for higher education; Doctor draft amendments; Federal charter for National Fund for Medical Education; Factory inspection by Food and Drug agents; Presumption of service connection for tuberculosis; Eliminating medical supervision of Army food preparation; Broadening the Vocational Rehabilitation Act; Creating National Mental Health Week; Aid to Philippines for veterans; Medical expense tax deductions; Permitting oral narcotic pre-

scriptions; Social security amendments; Life insurance for federal employees; and amending Unemployment Compensation Act.

We may expect the President to renew his request for a reinsurance plan in the next Congress which convenes on January 5, 1955. Neither the medical profession nor the insurance companies seem to have been successful thus far in convincing him of the lack of necessity for such a program. The President is also convinced of the need for increased medical care for military dependents and undoubtedly will urge support of this in the next Congress. We shall watch developments with interest. The suggestion has been made—and it is a good one—that each one of us pay our Congressman a visit or drop him a note to thank him for his past interest in our views and to tell him how we feel about some of the issues of the day.

More Doctors For America

Critics of the medical profession who have been wildly claiming an alleged shortage of doctors and a scarcity of teaching facilities will find no comfort in the latest annual report on medical education in the United States.

That report, by the American Medical Association, tells a heartening story of continued progress and expansion to produce an ever increasing supply of well trained physicians dedicated to the welfare of their patients. Among the highlights:

—The number of doctors is at a record low ratio of one for every 730 persons, a proportion exceeded



only by Israel, which has an abnormal number of refugee physicians.

—The nation's medical schools have record total enrollments and graduating classes and the largest freshman class.

—Ten new four year medical schools are scheduled to begin operation within the next five to six years, and three more are under consideration.

The expansion bears out the opinion of many medical education experts that the big problem in the near future may be a shortage of well qualified applicants rather than a shortage of teaching facilities.

Young people will be interested that only 21 per cent of the freshmen entering medical school last fall had "A" averages in their premedical studies, 69 per cent had "B" averages and 10 per cent had "C" averages.

In other words, they don't have to be "grinds," bookworms or Phi Beta Kappas to get into medical school. Most young people who have the character and a sincere desire to serve their fellowmen as physicians have an excellent chance of entering medical school.

### The Incurable Cancer Patient

Life is dear to almost every human being. It has always been the function of the physician to preserve life and to prolong it under the best conditions possible. Strangely enough when patients with incurable cancer must be cared for there are some who immediately become therapeutic nihilists and afford no measures to tide the sufferers over the rough spots. Not even do these physicians have the good grace to render the spiritual encouragement which they should for the physician is a minister as well as a healer. This all serves to boost the stock of the proponents of euthanasia. The good internist and the good physician will recognize his obligation to the sick and suffering.

Elsewhere in this issue Dr. Lemuel Bowden, from his experience at the Memorial Center for Cancer and Allied Diseases in New York City, offers some very concrete measures which may be utilized in the surgical care of patients with advanced cancer. Some of these measures have added a few months to the life of the sick one, others a few years, but in each

instance they have been years of less suffering than otherwise would have been the case.

Too much emphasis cannot be placed on one fact, that the incurable cancer patient may be heir to acute episodes requiring immediate remediable surgery just as any other individual may experience. Because of lowered resistance he demands the best in surgical judgment and technique.

### The Specialty Board

In his presidential address before the Advisory Board of Medical Specialties, Robert A. Moore of St. Louis has presented very clearly the proper place the specialty board should occupy in the practice of medicine. We are fortunate to be able to present the text of this speech in our columns this month. There is much grist contained therein for the intellectual mill. He points his finger sharply at what he terms the fundamental defect of medical education today, namely, the teaching of more and more specialties and less and less medicine. Our medical schools are culpable for this state of affairs but they have suffered much from pressure from without and should not alone be held responsible.

How often we hear a young intern or resident say, "I want to learn more about this disease or that surgical procedure or a certain pathological lesion in order to qualify for the Board," when, as Dr. Moore points out, the basic reason should be expressed, "in order to improve my knowledge of medicine."

Complaints have been expressed, and rightfully so, that our specialty boards are setting up standards of medical education. This must never be if we wish to maintain progress. No one will deny that the specialty boards have made a real contribution to the improvement of medical practice in the United States. They must be recognized for what they are, in the words of Dr. Moore, "voluntary agencies concerned with the certification of the competency of professional health personnel in limited fields of practice." It is that competency which we as practicing physicians should do all in our power to develop in order that our successors, the physicians of tomorrow, may be well qualified to provide the best in medical care for their patients.

It was Sir William Osler who said "To have striven, to have made an effort, to have been true to certain ideals—this alone is worth the struggle."

### Thoughtful Progress

The recent decision on the part of the State Administration to convert Undercliff Sanatorium into a facility for the chronically ill, aged and infirm, is a significant development which has caused expression of widely divergent views.

On one hand, the *Hartford Courant* describes the event as "a milestone in institutional history." In an editorial, the *Courant* states, "Not only is the Tuberculosis Commission's act unique, but it speaks more than volumes could about the effective manner in which tuberculosis is being controlled in this state."

On the other hand, the New Haven Area Tuberculosis and Health Association expresses misgivings in its September number of "Your TB Association Reports . . ." They are quick to point out that "approximately 30 per cent of all TB patients leave state TB hospitals without physician consent—some still in a contagious state. Financial problems are responsible for some of these premature and unwise departures. . . . And it is a fact that most Connecticut communities have residents with active, contagious TB . . . ."

As physicians, we must at this juncture be wary lest we succumb to the fallacy that the entire TB problem has been solved in our state, even though it was possible to release a 300 bed institution at this time. Vigorous efforts designed to further reduce morbidity and mortality from this disease must be continued.

We should also recognize that the decision was not made simply because of the reduction in hospitalized tuberculosis cases, but because the State has felt that a more concerted effort must be expended for the chronically ill and elderly. In recent years we have seen Connecticut develop a far-reaching program designed to rehabilitate the handicapped and to treat infirm elderly patients in settings other than mental hospitals. This program of the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm has made strides virtually unequalled in the nation. The addition of Undercliff to its facilities at this time should enable a notable demonstration of the true value of this approach.

This Society has been in close contact with the program of the Commission for the Chronically Ill and Aged since the beginning. The plans to approach the operation of Undercliff as not simply a service program, but as an opportunity to deter-

nine the ultimate effect on the mental hospitals of expansion of their facilities, can only be endorsed as a much-needed step in the right direction.

We are witnessing a phenomenon in State administration which represents the kind of good government that has always made Connecticut an advantageous place in which to live and work. Here is demonstrated rare cooperation between the three agencies concerned with the institutional care of patients for whom the State feels a responsibility. The Tuberculosis Commission, the Mental Health Commission, and the Commission for the Chronically Ill and Aged should all be congratulated on their joint planning and real concern for the needs of all the people of the State.

We feel that this present demonstration of cooperation between the agencies, gives assurance that the present conversion is not irreversible, should tuberculosis beds again be required. It should be noted that in a report submitted by the heads of these three agencies in July, 1954, they themselves expressed the need for flexible planning should the present anti-tuberculosis drugs lose their effectiveness. It seems preferable to utilize the facilities now for non-infectious chronic disease and to reconvert for TB if necessary, rather than leave valuable facilities vacant against an eventuality which may never occur.

An aspect of this development which is of salient importance is the opportunity afforded for demonstration that adequate facilities, staffed with sufficient numbers of high quality physicians, nurses, therapists can accomplish a real measure of control of a major health problem. It also represents an investment in professional skills which can readily be adapted to other related problems as they arise. We hope that this demonstration in tuberculosis will encourage our professional workers in other fields to new effort. We hope it will encourage our elected representatives to take bold strides to meet our mental health and chronic illness problems as effectively.

We trust that in the utilization of Undercliff for the chronically ill and aged, effort will be concentrated on controlling the new cases arising so that early treatment will prevent them from becoming custodial problems impossible to reclaim. We look forward to the day when all our institutions can meet the needs of the patients who require their specialized facilities, and are stabilized at the point



where annual discharges equal annual admissions. We salute the present change at Undercliff as a significant event which tends to bring that day closer.

### Accuracy in Medical Observation

While medicine is not a science but a mixture of science and art, there is no reason why measureable physical finding should not be accurately recorded, especially in those patients in whom the only necessary mechanism is a properly graduated tape measure. Of course there are patients in whom accurate measurements are not particularly important, but there are others in whom changes in the size of measurable abnormalities is decidedly significant.

The writer's attention was focussed on this aspect of medical recording by a recent report in which a patient was stated to have a palpable abdominal mass "approximately the size of a honey dew melon." We recall a much older report in which a patient was described as having a pulmonary cavity "the size of a walnut with the shell off." Descriptions of masses the size of an orange or a grapefruit are quite common, though in the latter instance it is not usually stated whether the recorder is referring to a Florida, Texas, or California grapefruit. Other common statements are to the effect that the liver, or spleen is palpable "3 fingers' breadths below the costal margin" although obviously all fingers are not of the same width and the costal margin is not a straight line.

There are two aspects of such inaccurate methods which are important, the psychological and the objective. The use of such casual appraisals raises the question whether the observer is not also inaccurate in other clinical observations and, in some patients it is important to know whether a mass or an enlarged organ is increasing or decreasing in size. Accurately graduated metal tape measures are not expensive and are easy to carry. Why not use one?

G. B.

### Personal Incomes

From time to time the JOURNAL comments on economic affairs in our State in the belief that the economic climate has a direct influence on the practice of medicine. Persons with comfortable and high-level incomes are bound to demand and be able to afford superior medical service. The people of Connecticut fall into this group.

The U. S. Commerce Department has recently reported on personal incomes for 1953 and shows an increase in all except five States.

The top gainers were Michigan, Florida, South Dakota, Ohio, Indiana and Nevada, where individual income totals rose by 9 to 12 per cent. The overall national average of personal incomes was up to \$1,709, an increase of 6 per cent compared with the year before.

Per capita income exceeded the national average in 17 States. In nine States, including Connecticut, the per capita was above \$2,000 per year. Delaware had the highest average income, \$2,304 and only two states—Mississippi with \$834 and Arkansas with \$939—had per capita income of less than \$1,000.

The following tabulation shows for each State the estimate of total income for 1952. The figures are listed in order of total income for 1952; total income for 1953; per cent of change from 1952 to 1953; per capita income, and per cent of national average of per capita income in 1953.

United States: \$256,091,000,000; \$270,577,000,000; up 6 per cent; \$1,709; 100 per cent.

New England: \$16,707,000,000; \$17,686,000,000; up 6 per cent; \$1,824; 107 per cent.

Connecticut: \$4,393,000,000; \$4,744,000,000; up 8 per cent; \$2,194; 128 per cent.

Maine: \$1,250,000,000; \$1,287,000,000; up 3 per cent; \$1,369; 80 per cent.

Massachusetts: \$8,421,000,000; \$8,880,000,000; up 5 per cent; \$1,812; 106 per cent.

New Hampshire: \$781,000,000; \$818,000,000; up 5 per cent; \$1,620; 95 per cent.

Rhode Island: \$1,362,000,000; \$1,429,000,000; up 5 per cent; \$1,749; 102 per cent.

Vermont: \$500,000,000; \$528,000,000; up 6 per cent; \$1,401; 82 per cent.

Thus it will be seen that Connecticut is among the top ranking States, a position that it consistently occupies, and is the most favored State in New England.

### Carol and Edna

If the arrival of this issue of the JOURNAL is delayed, the blame must be placed on those two furies, Carol and Edna, who recently visited New England and vented their spite on its industrious and long suffering inhabitants. Not satisfied with denying us electricity, the means by which we sustained our

very existence in obtaining water and food, for four days the second bout of nature deluged us with eight inches of rain in half as many hours and left in its wake a shambles of fallen trees, washed out roads and wrecked boats.

Your editor rode out both storms on an island off the Maine coast where he had gone for a period of rest and mental as well as physical recuperation. Carol did her worst, sending ocean spray inland for two miles and leaving a brown blight on the foliage which reminded one of those late spring frosts which catch Mother Nature unfolding her plumage at an unpropitious time. Seemingly to out do her vicious sister, Edna added to the onslaught eleven days later by blocking much of the transportation in the Pine Tree State, including boat service to the islands and all rail communications along the seaboard, and leaving the trees as bare as in winter.

It was a grim vacation.

## THE DOCTOR'S OFFICE

Monroe Coleman, M.D. announces the opening of an office for the practice of allergy at 86 Prospect Street, Stamford.

Stephen H. Deschamps, M.D. announces the opening of an office for the private practice of internal medicine and gastroenterology at 923 East Main Street, Bridgeport.

Charles Frederick Dyer, M.D. announces the opening of an office for the practice of general surgery at 302 State Street, New London.

Marvin Garrell, M.D. announces the opening of an office for the general practice of medicine at 205 Stillson Road, Fairfield.

Anton N. Lethin, Jr., M.D. announces the opening of an office for the practice of pediatrics at 45 Main Street, Middletown.

## Diabetes Drive

For six years now the American Diabetes Association has conducted a Diabetes Week. At first it was called "Diabetes Detection Drive" and the emphasis was on testing urines for sugar from as many persons as possible. This was an attempt to find the million unknown diabetics in our nation and get them under treatment before irreparable damage had been done.

In the last two years the special week has been called Detection and Educational Drive and to this it would seem the public has responded even better.

More and more people take a sample of urine with them when they go to the doctor's office. For the most value the doctor should insist on a urine voided two hours after a meal. When sugar is found in a sample of urine, the patient is already on a carbohydrate restricted diet before a blood sugar can be taken next day, so a blood sugar should be taken on the spot. The chances are it will be worth more than a glucose tolerance test later.

Recently many people recognize the polyuria and thirst of diabetes and specifically request a diagnostic test. This and other educational factors explain the fall in admission of diabetics in coma to the major hospitals.

The Seventh Diabetes Drive will be November 14 to 20 and is sponsored by the Connecticut Diabetes Association and also by the various co-medical associations.

It is hoped that during this period each doctor will cooperate by doing a routine urine examination for sugar on each patient who comes to his office.



## PROGRESS IN CLINICAL MEDICINE

### LENTE INSULIN

BARNETT GREENHOUSE, M.D., *New Haven*

**L**ENTE INSULIN, a newer type, long acting insulin, marks a notable departure in insulin preparation. It is a cloudy insulin suspension containing a small amount of zinc (0.2 mgm. per 100 units) and is slowly soluble at the pH of the blood. It is not unlike NPH Insulin in appearance and action except that the retarded effect is obtained without the use of protamine, globin or other modifying proteins. The prolonged action of Lente Insulin is achieved rather by the use of small amounts of zinc which in the presence of an acetate buffer has been found to have a sustaining effect upon insulin.

The significance of employing an acetate buffer, rather than the phosphate buffer routinely used in insulin preparation, lies in the recent discovery that phosphate ions have an affinity for zinc, precipitating it out of solution, and by changing to an acetate buffer, which does not have as great a degree of affinity, zinc could be made to combine with insulin in such a way that the resulting product was relatively insoluble at pH 7.2.

Thus a simple method of prolonging insulin action is achieved with zinc alone and without the need of the delaying action of protein modifying agents. Indeed, protamine and globin might not have come into use had it been recognized earlier that phosphate ions have such an inhibiting effect on the physical-chemical relation between zinc and insulin.

#### INTERACTION BETWEEN ZINC AND INSULIN

Zinc is an essential element in the framework of insulin, greatly influencing its action. It is capable of precipitating insulin and is a necessary factor for its crystallization. The retarding effect of zinc on insulin made insoluble by combination with protamine and globin is well known and is the basis for

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*The Author. Attending Physician in Medicine, in charge of the Metabolic Service and Diabetic Clinic, General Service Medical Staff, Grace-New Haven Community Hospital, New Haven, Connecticut; Governor of the American Diabetes Association for Connecticut*

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#### SUMMARY

Lente Insulin is the most recently developed intermediate-acting insulin modification. It is a cloudy and slowly soluble insulin-zinc suspension closely resembling NPH Insulin in appearance and action but containing no protamine. Its prolonged action is obtained by the use of zinc alone in the presence of an acetate buffer.

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Protamine Zinc Insulin, NPH and Globin Insulin with Zinc. The new discovery is that insulin alone, in precipitated state, together with a small quantity of zinc gives a prolonged insulin effect.

The precipitated insulin containing 0.2 mg. of zinc per 100 units can be made to take two different forms depending upon pH adjustment. A crystalline form is quite insoluble and, therefore, is absorbed slowly by the body. Total activity has been shown under experimental conditions to exceed ninety hours. An amorphous form containing precisely the same amount of zinc is more easily dispersed and absorbed by the body tissues and, therefore, has a much shorter activity—about twelve hours.

By combining the two forms, one can arrive at intermediate preparations aimed at approximating the desirable action of NPH Insulin, and a mixture consisting of 70 per cent of the crystalline form and 30 per cent of the amorphous form was found by trial to be the most satisfactory.

*From Dr. Greenhouse's Clinic, Grace-New Haven Community Hospital*

*Presented at the Clinical Session of the Interim Convention of the Phi Lambda Kappa Fraternity held in Miami Beach, Florida, April 2, 1954, and at a Symposium on Diabetes held during the Annual Meeting of the Connecticut State Medical Society in Hartford, April 29, 1954*

Dr. K. Hallas-Moller and his associates of Denmark who developed these new forms named the very slow acting crystalline form Ultra-Lente; the short acting amorphous form Semi-Lente, and the intermediate combination simply Lente. The term Lente means slow.

#### CLINICAL USE OF LENTE INSULIN

Our clinical observations for the past nine months seem to indicate that Lente Insulin is an intermediate acting insulin in the same category with NPH and Globin Insulin. However, it does have a longer action approaching rather that of Protamine Zinc Insulin as evidenced by a recurrence of early morning reactions. In its present form it is probably too long acting and not rapid enough to overcome the glycosuria after breakfast. Generous bedtime feedings are necessary to prevent reactions during the night, and the added use of crystalline insulin is often needed to hasten the insulin effect at breakfast.

Lente Insulin may otherwise be used interchangeably with NPH, unit for unit, though less of the Lente Insulin will often be required. As with other insulins, patient reaction will need to be individualized and dosage adjusted according to response to treatment.

We have adopted the same procedure with Lente Insulin as we have with NPH Insulin. The meals are equally divided but allowing a substantial feeding before retiring, and often also a snack in mid-afternoon. The insulin dosage is controlled mainly by the second specimen on arising. Just enough insulin is given to keep this specimen sugar free, and if sugar appears later on during the day, 5 to 15 units of crystalline insulin are added in the same syringe with the Lente Insulin to sharpen its effect. Attempts to keep sugar free on Lente Insulin alone in higher dosage levels have caused severe and precipitous reactions during the night. As a result we have learned to cut back on the Lente Insulin and add a little crystalline insulin with good effect.

When the dose of Lente Insulin is unduly large, the danger of insulin reaction is increased. This may be offset by divided insulin dosage, giving two-thirds of the total daily dose before breakfast and one-third before supper. The morning insulin is

adjusted for daytime control, while the supper dose is regulated to cover the evening and early morning hours. Often as little as 5 to 10 units may be sufficient at supper time. If needed, crystalline insulin may be added to the morning dose but it is wiser to avoid doing so with the supper dose of Lente Insulin for fear of night reactions.

#### INSULIN ALLERGY

Because of the highly purified crystalline state of Lente Insulin and the absence of foreign proteins, it was anticipated that the incidence of allergy would be less following its use. However, we have since had two patients with an allergic response. The local skin reactions subsided in one patient without changing the insulin. The other, a known case of insulin allergy, had to discontinue Lente Insulin and go back on Special (Beef) NPH Insulin to which she was less sensitive. It was suggested that we might have here a case of species specificity since the recrystallized insulin used in Lente Insulin is made from both beef and pork.

#### COMMENT

Lente Insulin is the third intermediate acting insulin to become available, supplementing NPH and Globin Insulin. Subtle differences in action may be observed between the three insulins giving the physician a wider choice of insulin effects. The advantages of Lente Insulin lie not in its superiority to NPH or Globin Insulin clinically, but rather in the basic principle of its preparation and the elimination of foreign protein modifying agents. The possibilities offered by the newer crystalline insulin compounds are intriguing, and open new avenues to the insulin of the future.

#### ACKNOWLEDGMENT

The author wishes to express his appreciation to Drs. Franklin B. Peck and William R. Kirtley of the Lilly Research Laboratories for the insulin supplies used in this clinical study.

#### REFERENCES

- Collected papers on Zinc Insulin Preparations (NOVO) and personal communications from the Lilly Research Laboratories.
- Greenhouse, B.: NPH Insulin, Connecticut M. J. 15:321, April 1951; NPH Insulin, Med. Times 80:706, Nov. 1952.



## THE PRESIDENT'S PAGE

### THE THERAPEUTIC TRIAL

**T**he past thirty years have witnessed the introduction into medicine of scores of diagnostic tests, many of them having specific significance. It is natural and inevitable that as these tests have increased in number and specificity, physicians have placed less and less reliance upon the deductive reasoning and trials of therapy that formerly aided in reaching correct diagnoses.

To many of us who entered medicine several decades ago, it seems that diagnostic testing is sometimes carried to unnecessary lengths. Patients are admitted to hospitals in order that ten to twenty tests may be performed, relating to almost every organ or system of the body. If the diagnosis is really obscure, there can be no possible objection to this procedure, but sometimes the diagnosis can be made with confidence on the basis of a therapeutic trial. Let me speak briefly of several matters that lie within the range of my personal experience.

When an adult patient complains chiefly of difficulty in breathing at night, and is found to have enlargement of the heart or hypertension, most physicians think immediately of early failure of the left ventricle and of bronchial asthma as possibilities. The differentiation between these often can be made quickly by the administration of full doses of digitalis. If there is prompt relief of the symptom it is highly probable that the heart was responsible; if there is no relief, the chances are great that the dyspnea was not due to the heart. Similarly, the use of adequate doses of bronchodilator drugs may provide immediate and convincing evidence that the nocturnal breathlessness was due to bronchospasm.

Pain or pressure behind the sternum may be extremely puzzling at times, since it may be typical of angina in some respects but not in others. One may have to consider spastic phenomena in various portions of the gastrointestinal tract, hiatus hernia, disease of the gallbladder, pathological conditions in the spine, neurocirculatory asthenia, and perhaps several other conditions. Helpful, and sometimes crucial, information may be obtained by a careful therapeutic trial of nitroglycerine. True, this is not infallible, inasmuch as this drug occasionally relieves discomfort arising from organs other than the heart, but speedy, invariable relief from nitrites speaks strongly in favor of angina. Surely this simple test should be applied before the patient is subjected to the expense and loss of time involved in hospitalization or x-ray studies of the intestinal tract and gallbladder. This is especially true since there is at present no objective test that will prove the existence of angina. The diagnosis still depends upon the history, and the response to effort and to coronary artery dilators may be the most decisive items.

Occasionally adults with known heart disease but without heart failure complain bitterly of inability to sleep, and this symptom may not respond to the ordinary mild sedatives. In these circumstances one suspects that Cheyne-Stokes respiration may be responsible for the wakefulness, even though the patient insists that there is no abnormality of his breathing. If the suspected diagnosis cannot be confirmed by observations of members of the family, it may find ready confirmation in the response to respiratory stimulants such as aminophylline.

Undoubtedly there are many other conditions that can be identified readily on the basis of simple therapeutic trials. Even if the patient does have Blue Cross membership, it may be a serious disservice to him and to other members to arrange for hospitalization when it is not actually necessary. Most hospitals are finding it difficult to provide adequate space and service for those who are really ill; their concern over the numerous admissions for diagnostic study should receive the sympathetic consideration of every physician who uses their facilities. A far more serious objection to frequent "shotgun testing" is that physicians may become increasingly dependent upon laboratory tests, rather than upon their observations of patients and the responses to treatment. In fairness to them and to ourselves, let us not invoke the complex, costly tests now available until we have utilized to the full our clinical knowledge, diagnostic ability, and simple therapeutic tests.

H. M. Marvin, M.D.

## THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH  
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### INSURANCE AGAINST CATASTROPHIC MEDICAL EXPENSES

#### A Service for Members

Hospital and surgical insurance, both written through insurance companies and nonprofit plans like Blue Cross and Blue Shield, have made a major contribution to lessening the financial burden of illness and accident. These plans, however, insure against normal medical costs which may be termed "financial inconvenience," stopping far short of protection against a financial crisis that could easily develop in cases of prolonged illness or extensive disabilities. Major Medical Expense Insurance or Catastrophic Medical Expense Coverage, as it is sometimes called, was especially designed to give greater financial protection against large and unusual medical care expenses of all kinds. The first advantage of Catastrophic Medical Expense Coverage is its broad approach to the cost of medical care rather than the usual itemized breakdown of benefits into hospitalization, surgical, and so on, as the ordinary coverages normally do. The Major Medical Plan covers any reasonable and customary expense normally associated with the care and treatment of an accident or illness, including professional fees, private nursing, hospital charges, anesthesia, drugs and medicines. Instead of limits to hospital charges for board and room and a daily allowance for nurses' fees and to other miscellaneous fees, there is but one over-all maximum benefit limit for each person for each accident or illness; the most common amount being \$5,000. A basic amount is stipulated to which the charges must accumulate before the insurance coverage commences. This usually ranges from \$250 to \$500 depending on the premium charged, similar to the well-known deductible provision in automobile insurance. This deduction principle eliminates the many relatively small but costly-to-process claims which in most cases can easily be met by the insured. It makes possible, at a reasonable premium, the extension of this insurance into areas of expense where a real financial catastrophe could occur.

Catastrophic Medical Expense Plans of most companies also include a form of coinsurance. This means that the insured pays a certain proportion of the additional costs over and above the original deductible amount. This coinsurance is usually 20 or 25 per cent of the total expense and it is based on the premise that some financial responsibility is necessary so that the insured will be concerned with the cost and frequency of medical treatment being rendered. Unnecessary services must be avoided if premium rates are to be kept at reasonable levels.

With these facts in mind, the Connecticut State Medical Society in cooperation with representatives of the Commercial Insurance Company, devised a plan for insurance aimed at helping members of the Society meet these unexpected major medical expenses. It was found that experience and statistics

were virtually nonexistent, so that the Commercial Insurance Company wrote the plan with the understanding that it would be extended as experience indicated. On April 15, 1952 the first Professional Men's Group Catastrophic Medical Expense Plan went into effect for members of the Society, with an enrollment of better than 50 per cent of the eligible membership.

The coverage provided is as follows:

1. The member pays the first \$500 of medical expense incurred as a result of any one illness or accident. Inability to work is not necessary to receive benefits. It is assumed that in most cases other types of insurance would absorb the first \$500 of expense but the fact that other insurance entered the picture had no bearing on determining the deductible clause in the Society's group contract.



2. Our plan pays 80 per cent of the medical expenses in excess of \$500, up to a maximum amount of \$5,000 incurred within two years for any one cause. Each new illness or accident and each member of the family has available the maximum benefit of \$5,000.

3. Medical expense in the contract is defined as all reasonable charges necessarily incurred for medical; surgical; hospital; or nursing; also x-ray examinations and treatment, laboratory service, anesthesia, drugs and medicines, and all other therapeutic services and supplies, which may be needed as a result of any accident or because of all sickness resulting from one cause.

4. The age limit is 70 years.

5. The coverage is available to the insured member's eligible dependents. Eligible dependents are unmarried children under 23 years of age and the member's spouse under 70 years of age.

6. The insurance does not provide for a maternity benefit in normal pregnancy, which is not considered catastrophic. Protection is provided, however, for the extraordinary complications of pregnancy, when benefits are payable in the same manner as for other illnesses.

7. The plan cannot be cancelled individually by the Company, except for nonpayment of premium or withdrawal from membership in the State Medical Society. Neither member nor any member of his family can be refused renewal on the basis of a change in physical condition after becoming insured.

Claims actually paid give ample testimony to the need for this kind of insurance and to what it is accomplishing for our members. Several claims have already been paid in the amount of \$5,000. The average payment on claims up to now has been \$853, proving clearly that the plan is making payments of financial importance to the individuals affected.

There is always the possibility of over use or abuse of such a plan. It is only fair to say that the bills that have been presented have often been substantial, but that is not unexpected when the economic level of the insured persons is taken into consideration. So far, in our experience, there has been no indication of services being unnecessarily provided, or that charges are inappropriately high.

None of these plans can be a success without the intelligent cooperation of the group insured and it is

a pleasant duty to report that, with the completion of two years, the Catastrophic Medical Expense Plan of the State Medical Society is an unqualified success. All information concerning it can be obtained from the Secretary's office.

### Advisory Committee to Tuberculosis Commission

At the invitation of the Tuberculosis Commission, the Council of the Society appointed a Medical Advisory Committee to the Commission: Gustaf E. Lindskog, New Haven, Chairman; Ettore F. Carniglia, Hartford; H. M. Marvin, New Haven; Albert W. Snoke, New Haven; Charles F. VonSalzen, Hartford.

### Physicians in Selective Service

July 31 compilation by Selective Service reveals following totals of living special registrants: physicians, 114,476; dentists, 42,868; veterinarians, 8,812. Included in these figures are Priority IV registrants, who obviously will not be reached—or even classified—under doctor draft law, barring full scale military mobilization. Following are principal breakdown figures on Priority I, II and III physicians and dentists (no draft calls for veterinarians are anticipated):

#### PRIORITY I PHYSICIANS

Total, 9,474, of whom 9,405 have been classified. Physically fit and available for induction are 371. As of July 31, 4,418 were on active military duty and 1,619 held Reserve status after having fulfilled, in many cases, obligated service. Holding essentiality deferment (2-A) were 449, and 1,721 were in 4-F. Involuntary inductions to date total 14.

#### PRIORITY II PHYSICIANS

Total, 2,053, of whom 2,000 classified. Fit and available for induction, 166; 631 on active duty; inactive Reserves, 457; holding essentiality deferment, 175; in 4-F, 311; one involuntary induction.

#### PRIORITY III PHYSICIANS

Total, 37,433, of whom 34,930 classified. Fit and available, 8,187; 1,858 on active duty; in 2-A (essential), 4,978; 4-F, 7,264; overage (past 51st birthday), 4,805; deceased, 520; two involuntary inductions. Note: In Priorities I and II deceased total is 91.

## Meetings Held in September

- September 7—Professional Policy Committee CMS
- September 8—Committee on Neonatal Mortality
- September 9—Committee on Public Health  
Budget Conference
- September 15—Clinical Congress  
Board of Directors CMS
- September 16—Clinical Congress
- September 16—Committee on Revision of By-Laws
- September 21—Committee on Hospitals  
Committee on Cancer Treatment  
Survey
- September 22—Committee on Maternal Mortality  
and Morbidity
- September 22—Cornell Crash Research Committee
- September 23—Committee on Payments for Non-  
Surgical Services
- September 23—Committee on School Health
- September 28—Advisory Committee to Welfare  
Department
- September 29—Connecticut Medical Examining  
Board
- September 29—Executive Board of Committee on  
Industrial Health
- September 30—Committee on Public Relations

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## New Medical Advisory Committee for the State Tuberculosis Commission

PAUL S. PHELPS, M.D., *Hartford*

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The Author. *Director, Connecticut Tuberculosis  
Commission*

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Tuberculosis is a chronic disease communicable in nature. It has caused untold numbers of deaths since the history of mankind has been recorded. It has and still does cause prolonged disability, not to mention the distress to patients and their families. Tuberculosis is a serious economic drain on families, the State, and the Nation.

We are beginning to see the results of the long fight against this disease in a tangible way. This has come about through a combination of factors of which the developments in Connecticut furnish an

excellent example. Modern hospitalization for the tuberculous in Connecticut has developed a high degree of effectiveness providing isolation, treatment, rehabilitation and education. Preventative programs throughout the State have provided case finding and follow-up facilities. Living conditions have improved. Most of these factors have taken years to develop. In recent years the factors which have had the most striking effect on deaths and disability from tuberculosis have been the development of modern chemotherapy and pulmonary resection. These two methods of treatment combined with isolation and rest have made it possible to reduce the number of deaths from tuberculosis dramatically. The reduction in Connecticut has been from 579 in 1946 to 175 in 1953. It has made it possible to reduce the length of hospital stay and to do away with the waiting lists. As this length of hospital stay has steadily decreased, vacancies have occurred in sufficient numbers during the last year to make it possible to consolidate from five to four tuberculosis hospitals in Connecticut. Strangely enough, this has occurred during a year when admissions were the greatest in ten years. This has not just happened; it has been the combined effort of both lay and professional people.

Tuberculosis is not licked (well over 1,000 new cases reported last year), and there are many factors concerning the modern treatment of tuberculosis about which we know very little as sufficient time has not elapsed for the research required.

Several months ago the Tuberculosis Commission, taking cognizance of the rapidly changing picture in tuberculosis control, requested that the State Medical Society appoint an informal Medical Advisory Committee to the State Tuberculosis Commission. The purpose of this was to review recent events in the tuberculosis control program and give the Commission the benefit of its advice and assist in planning a long-term program. The Tuberculosis Commission looks forward to this cooperative undertaking.

The members of the Society selected by the Council to serve on this Committee are: Gustav E. Linds-kog, 789 Howard Avenue, New Haven; Ettore F. Carniglia, 85 Jefferson Street, Hartford; H. M. Marvin, 303 Whitney Avenue, New Haven; Albert W. Snoke, 789 Howard Avenue, New Haven; Charles F. Van Salzen, 725 Asylum Avenue, Hartford.



## THE HISTORIAN'S NOTE BOOK

### IT WAS EVER THUS

HERBERT F. HIRSCH, M.P.H., *Hartford*

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The Author. *Health Director's Assistant and Director, Bureau of Vital Statistics, Hartford Health Department*

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MANY today who are becoming a bit tired of living a thermonuclear type of existence, tend to look back on the horse and buggy days of the '80s and long for those seemingly placid days of contentment and security. In doing so the fact is often overlooked that those nostalgic times were for many people neither placid nor secure. It was an era of contrasts wherein could be found excessive wealth on one side of the railroad tracks and abject poverty on the other. For men like Andrew Carnegie it would be possible at the turn of the century to acquire, tax free, a personal income of 23 million dollars per year. For the skilled worker, however, things were different. He could, if he were lucky, acquire on the average four to five hundred dollars a year (\$1,500 our money). For this he would work ten hours a day, six days a week! The lot of the unskilled foreign worker, of which there were many, was neither gay nor secure. Many eked out a miserable pittance and lived in an environment of filth, overcrowding, wretchedness, and degradation beyond the concepts of modern society. It was under such prevailing conditions, at about the time of the inauguration of Grover Cleveland in 1885, that the Board of Health of the City of Hartford came into existence.

Considering the formidable character of the work to be accomplished one might assume that such an undertaking would have been launched with a well rounded and suitably endowed organization. This was not so. The Board was staffed by two physicians with titles of President and Secretary, and a sanitary inspector thrown in for good measure. The first annual appropriation was for \$2,000, and this was not exceeded.

In 1885 the life of a sanitary inspector, like the proverbial policeman, could not have been a happy

one. Hartford had its problems. Those were the days when few houses had water closets, most relied on backyard privies and these were generally enhanced by an adjoining horse stable with its inevitable fly-borne manure pile. What sewers existed were inadequate; the Park River for years was a veritable cess-pool and a stench to the nostrils of those who lived near it. Streets, gutters and alleys were dusty, cluttered with filth and "buzzing" with flies. The people themselves were not much better off. The "Saturday night" bath was a privilege few could afford. For the rest, the Board of Health had this to say, "The need of establishing free public baths becomes more apparent year by year. Many of our people come from continental cities where there are such baths and in their new homes, not having such facilities they become neglectful. The water meter charges by the drop and a bath becomes a luxury which they cannot afford. Water, the necessity of all necessities, should be absolutely free." Oh happy thought!

Medicine in the '80's was on the threshold of a golden era. The science of bacteriology was coming into its own. Robert Koch had just discovered the tubercle bacillus and the cholera vibrio. Gaffky, Klebs and Löffler were doing things with typhoid and diphtheria. Within a few years Von Behring would be bringing to long suffering humanity, both tetanus and diphtheria antitoxin, while in far off Hong Kong the organism of bubonic plague would soon become identified. In this country the importance of contaminated water and its purification by slow sand filtration was being considered and the science of sanitary engineering developed. These were brand new discoveries and it would take time to digest and assimilate them. After all, people who for generations had believed pestilences to be the product of noxious vapors and atmospheric disturbances could hardly be expected to accept the germ theory of disease with too much enthusiasm or alacrity! Thus the Board of Health of those days constantly referred to zymotic diseases, those assumed

to be due to the presence of filth and unsanitary conditions. These included, among others, scarlet fever, diphtheria, infant diarrhea, typhoid, malaria and measles. They constituted a formidable group with a mortality which at times reached 40 per cent of all deaths within the community.

Compared to modern standards, the mortality among children was appalling! Twenty to 30 per cent of babies born during one year could be expected to die in the next. During the hot summer months of June, July and August, infant diarrhea was a terrible problem with deaths often running well over the hundred mark. None of this is really surprising. There were no pediatricians, no hospital wards for children and no adequate nursing care. Refrigeration, as we know it, was nonexistent. Milk would be poured from can to can in the streets and exposed to dust, filth and flies. If milk did not sour within twelve hours of delivery, one could be pretty sure that the milkman had surreptitiously added some antiseptic! Added to these unsanitary conditions was the common practice of attaching to the baby's nursing bottle a long rubber tube so that the milk could be delivered by gravity flow. The Board of Health objected to this practice and did its best to confiscate these contraptions.

To meet these conditions a few far-sighted physicians of Hartford organized around 1905 a Babies' Hospital. This sounds impressive. Unfortunately it consisted of a tent erected in Riverside Park which became so hot during the day and so miserably cold at night, thanks to the river fogs, that it was abandoned two years later. By this time a public spirited citizen contributed a tract of land on Mather Street on which was built a semipermanent building, if you would care to call it that, which had a board floor with sides going up shoulder high and a canvas top. This lasted until about 1915. By this time the two general hospitals in Hartford had well equipped children's wards.

Life expectancy in the '80's was about 45 years—a good twenty years below what it is today. If one didn't die of a "zymotic" disease in infancy the chances were that one might very likely succumb to pneumonia or tuberculosis during adolescence. These were the leading causes of death of that day and surely they must have had a fertile field in which to grow. This was the era of the brass spittoon in which the art of expectorating reached magnificent heights. It was also a time in which children worked long hours in mills and factories

under deplorable hygienic conditions. The adoption of Child Labor Laws might well have been beyond the scope of the Board of Health but not so the manly art of expectorating and it is refreshing to note that by 1911 some progress had been made in suppressing it. "There has been a decided reduction in the amount of spitting on the sidewalk. Using the method adopted last winter of counting the number of fresh marks in a given stretch of sidewalk, some of the streets near the center show a reduction of 60 per cent from last year." Thus spoke our ever watchful defenders of the public health!

Today if we face what seem insurmountable problems, we can take courage from the example set by that indomitable group which strove for years to accomplish, according to the dictates of the time, what seemed best for the welfare of this city. They too faced apathy and inertia. They too were opposed by militant minorities who forever seek to obstruct scientific advancement. The frailties of human nature were such that they too became discouraged, as witness this written in 1891. "While the poor plumbing and drainage of dwellings may be the cause of zymotic diseases, I find that poverty, intemperance and personal uncleanness are prime factors for the same. It is often easier to have the plumbing corrected than the personal habits of the individual!"

Appreciation goes to Dr. Charles P. Botsford, Health Officer of Hartford, 1907-1935 for supplying the historical references on child care.

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## New Record for Today's Health

With the October issue, *Today's Health* will reach a circulation of over 340,000 copies, which is the highest circulation figure in its 31 year history as *Hygeia* or under its present title. A substantial part of this increase in circulation is due to the diligent efforts of the Woman's Auxiliary to the American Medical Association and their subscription projects at the national, state, and local county level. The Woman's Auxiliary has devoted a great deal of their program to the promotion of subscriptions, because they recognize that the magazine can fulfill its purpose only when it reaches the persons for whom it is written. *Today's Health* is now found in the reception rooms of more than 103,000 physicians and 45,000 dentists throughout the United States and possessions. These copies are seen by many thousands of patients every week.



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## NEWS FROM WASHINGTON

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### Medical Legislation in 83rd Congress

In 1953, during the first session, the Administration was concerned mostly with laying the groundwork for the comprehensive health program introduced at the start of the second session early this year.

In the second session, Congress enacted much of that program. The only major part of the Eisenhower health program opposed by the AMA was the reinsurance legislation. The Association gave active support to most of the program and assisted congressional committees in perfecting the bills.

From the standpoint of the medical profession, this has been a very active Congress. Its members in general have given ample consideration to the views of physicians. The constructive record of this Congress in medical matters is in large degree a tribute to officers of State Associations and individual physicians who have taken the time, trouble, and expense to keep in touch with their Senators and Representatives.

During the two sessions 16,470 bills and resolutions were introduced, of which 407 were of interest to the medical profession.

#### SOCIAL SECURITY

HR9366 Social Security Amendments of 1954 was passed by the Senate August 13 and later signed by the President. The new bill extends coverage, increases benefits and taxes, liberalizes the retirement test, and maintains benefit levels of the disabled. Physicians and other self employed professional persons were excluded, but the President's recommendation on the method of waiving OASI premiums for the permanently disabled was adopted.

#### HILL-BURTON PROGRAM

The 1946 Hill-Burton Construction Act was expanded to permit the federal government to spend \$182 million in three years to help finance the construction of the new nonprofit facilities. Congress previously in 1953 extended the life of the Hill-Burton Act to 1960.

The expanded Hill-Burton construction program, signed by the President on August 27, will have \$21

million available for the next year for construction grants. In addition, Congress has voted \$2 million for State studies of future needs under the program which envisions an eventual expenditure of \$180 million over a three year period. The administration sought \$35 million for construction grants, but Congress thought \$21 million would be enough for the first year, particularly since it already had voted \$75 million for regular Hill-Burton hospital projects for this fiscal year.

The \$21 million was earmarked by Congress as follows: hospitals for chronically ill, \$6.5 million; diagnostic treatment centers, \$6.5 million; nursing homes, \$4 million; rehabilitation centers, \$4 million.

In its closing days, Congress also approved supplemental funds for the Department of Health, Education, and Welfare to carry out other expanded programs voted earlier in the session. They included \$4 million for State grants under the new vocational rehabilitation law; \$5 million for administering the broadened social security program, and \$1 million for water and air testing studies for the Civil Defense Administration.

#### VOCATIONAL REHABILITATION

The new law gives states more assistance and responsibility for rehabilitation programs in an attempt to increase from 60,000 to 200,000 by 1959 the number of disabled persons rehabilitated yearly. It also provides for special training for rehabilitation specialists, increased research on conditions that result in handicaps, and new benefits for the blind.

#### HEALTH REINSURANCE

Health reinsurance proposal was defeated. The AMA opposed this bill because voluntary health insurance is still growing at a phenomenal rate without government intervention, the need for such intervention had not been shown, and the bill did nothing to help individuals presently not insurable. Although reported out by both House and Senate committees, its firm defeat on the floor of the House marked the end of the proposal. The President, however, has already indicated that it will be resubmitted next year.

## PUBLIC HEALTH SERVICE GRANTS

The Administration bill to streamline Public Health Service grants was passed by the House but failed in the Senate to progress beyond the hearing stage.

## OMNIBUS TAX REVISION LAW

In completely rewriting the federal tax laws for the first time in 75 years, Congress lowered the medical expense tax deduction from 5 per cent to 3 per cent, doubled the maximum limitation on deductions, and liberalized other health and drug tax features.

## OTHER MEDICAL BILLS

Other measures of medical interest which became law during the 83rd Congress included: (a) the transfer of the Indian hospital and medical service from the Indian Bureau of the Department of the Interior to the Public Health Service of the Department of Health, Education, and Welfare; (b) a federal charter for the National Fund for Medical Education; (c) prohibiting the shipment of fireworks into a state where their sale is illegal; (d) extending the doctor draft act to 1955 and strengthening the Defense Department's position in dealing with physicians and dentists who might be security risks.

## Summary of Major Medical Legislation

## 83rd Congress

The following table sums up all major medical legislation of both session

SUBJECT	BILL NO.	HOUSE	SENATE
Bricker Amendment	SJRes 1		Rejected 2/26/54
Dependent Med. Care	HR9697	No Hearings	
	S3363		No Hearings
Fed. Hosp. Board	HR633	Hearings Held	
	S1436		No Hearings
Hospital Loans	HR7700	Hearings Held	
Pvt. Pensions	HR10-11	No Hearings	
	HR9618	No Hearings	
PHS Grants	HR7397	Passed 4/27/54	
	S2778		Hearings Held
Reinsurance	HR8356	Recommitted 7/13/54	
	S3114		Reported 7/1/54
Service-Connection	HR8789	Reported 5/12/54	
	HR9169	Reported 5/20/54	
Dr. Draft Extension	HR4495		Public Law 84
Dr. Draft Amendment	S3096		Public Law 403
FSA to HEW	HJRes 223		Public Law 13
Fireworks Ban	HR116		Public Law 385
Hill-Burton Exten.	S967		Public Law 151
Hill-Burton Expan.	HR8149		Public Law 482
Hoover Commission	S106		Public Law 108
Indian Hospitals	HR303		Public Law 568
Intergov. Relations	S1514		Public Law 109
Med. Tax Deduct.	HR8300		Public Law 591
Nat'l Fund Med. Ed.	S1748		Public Law
Oral Prescriptions	S3447		Public Law
Social Security Ext.	HR9366 (formerly HR7199)		Public Law
TB Presumption	HR5636		Public Law 241
Vocational Rehab.	S2759		Public Law 565



Congress rejected the Bricker constitutional amendment to restrict the government's treaty-making powers. The Administration actively opposed the resolution, and it was defeated in the Senate by a vote of 60 to 31.

Congress also declined to act upon: (a) a number of bills to make it a presumption that certain diseases were incurred from a veteran's military service, rather than upon a scientific basis; (b) bills to permit self employed persons to take tax deductions for their personal pension annuities; (c) legislation to offer free medical care to the dependents of military personnel; and (d) a bill to permit the federal government to contribute with its employees in purchasing health insurance.

### Army Taking 100 Physicians, First in 16 Months

Defense Department has asked Selective Service to call up 550 physicians under the doctor draft for assignments in December. One hundred are scheduled to go to the Army, the first since August, 1953. Defense said the Air Force requires 200 and the Navy, 250 physicians. The Department also requested 150 dentists, all for the Air Force.

### VA Administrator Outlines New Plan for Aging Veterans

Veterans Administrator Harvey Higley has outlined a new plan for federal care of the aged and chronically ill veteran to help solve a problem "that rapidly is becoming more acute." He made his proposals in an address to the American Legion national convention during which he also announced that the VA's program of constructing 174 new hospitals was near completion. Mr. Higley explained that special wings or wards could be set aside in general medical and surgical hospitals for treatment of diabetics, arthritics, amputees, pulmonary cripples, cardiacs, and patients with chronic neurological problems and some psychiatric cases. He also asked the veterans to contribute advice on (1) provision of enough money "in the very near future" for rebuilding, modernizing, and rehabilitating some VA hospitals, and (2) establishment of rehabilitation programs for veterans recovering from mental illnesses. He estimated 85,000 are receiving VA hospital or clinic care for mental disabilities and another

15,000 are on waiting lists for nonservice connected conditions.

### PVP-Macrose Cleared by FDA for Wide Use

Food and Drug Administration has granted new-drug clearance for PVP-Macrose (Schenley Laboratories), clearing way for general use of this synthetic plasma expander by physicians and hospitals. Heretofore its sale and distribution were limited to stockpiling for civil defense. In past three years PVP has undergone extensive research under military and civilian auspices.

### Illinois Society President Criticizes Administration

Willis I. Lewis of Herrin, Illinois, retiring president of the Illinois State Medical Society, in his address at the Society's annual meeting in Chicago recently made the statement that the medical profession has lost confidence in the present federal administration's promises that it would free the profession from the threat of socialism. Dr. Lewis emphasized the so-called blitzkrieg measures employed to force through acceptance of the new Department of Health, Education and Welfare and pointed out that in the end the medical profession was not accorded even a medical under secretaryship. He feels the special assistant for health and medical affairs assigned to the Department is only a figurehead.

Lewis said that although Mr. Eisenhower had declared himself flatly opposed to the socialization of medicine, his administration has given the nation's doctors cause for concern by pressing for three legislative proposals considered objectionable by the medical profession.

He listed these measures as the compulsory inclusion of doctors under the social security law, federal reinsurance of health care costs for substandard income groups, and a pending plan whereby physicians would certify permanently and totally disabled persons for maximum benefits under the old age pension program.

All three proposals, Lewis asserted, represent a federal effort to control the medical profession and illustrate the "creeping socialism" the profession has fought.

## THREE RECORDS BROKEN

America's medical schools set new records of achievement during 1953-1954.

- They achieved a record graduation of 6,861 new doctors of medicine.
- They reached an enrollment of 28,227 medical students, largest in the history of this country.
- They set a third new record in the enrollment of 7,449 students in the freshman class.

The fund raising activities of the American Medical Education Foundation and the National Fund for Medical Education were important factors in helping to achieve these records.

If you have not already contributed to the 1954 AMEF Campaign, you may use the coupon below to obtain a contribution card and information concerning the needs of the medical schools.

### Medical Education Needs Your Help

H. M. Marvin, M.D., President  
Connecticut State Medical Society  
160 St. Ronan Street  
New Haven 11, Connecticut

Please send a contribution card and information concerning the American Medical Education Foundation.

Name .....

Office Address .....

*(The figures cited above were taken from the American Medical Association's recently released 54th Annual Report on Medical Education)*



## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford  
James C. Canniff, Torrington  
Morris A. Hankin, New Haven

Harry C. Knight, Middletown  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

### "Medic," New TV Series Over National Network

On September 13, 9 P. M., a revolutionary new medical television series was beamed for the first time to millions of viewers across the nation.

The program carries the official endorsement of the Los Angeles County Medical Association and is sponsored by the Dow Chemical Company. The association's decision to engage in the program is the result of two years of study and deliberation. Each case described in the Medic series tells the story of the treatment of a patient and the script is approved in every instance by a medical committee.

The series is being written by James Moser, original writer of the "Dragnet" radio and TV productions. The programs have no single character around which the action is built; instead, the practice of medicine is cast in the leading role. The programs will be televised Monday evenings three times monthly over the NBC network at times to be announced.

### Emergency Plan Exhibit Now in Fairfield County

An exhibit portraying the growth of emergency medical call plans sponsored by medical associations, was recently displayed in the lobby of the Stamford Hospital under auspices of the Fairfield County Medical Association.

Designed for the Public Relations Committee of the State Medical Society, the exhibit is nine feet wide by seven feet in height and is illuminated to indicate the location and telephone numbers of the 15 major emergency call plans sponsored by county and local associations.

A leaflet describing the plans and the services they offer residents in sudden emergencies is furnished in quantities for distribution during display of the exhibit.

Previously displayed at the general hospitals in Hartford County, the exhibit will be similarly displayed at Fairfield County hospitals. It is designed to advance the story of community services sponsored by medical associations.

### New PR Manual for County Associations

The Public Relations Department of the American Medical Association has announced that a new manual on county medical public relations will be available for distribution some time in October.

The publication will be a working manual and will contain general public relations information and specific methods of organizing a program to achieve full effectiveness.

The manual also will contain dozens of practical public relations projects which medical associations may adapt to their own community service needs. An eight point basic program set forth in the manual contains the following list of projects: emergency call plans, mediation committees, press relations, speakers bureau; indoctrination of members; public service activities; citizenship activities and supplementary PR projects.

### "March of Medicine" To Be Televised October 24

The national television program, "The March of Medicine," will resume its two year old series of precedent breaking telecasts this fall, starting October 24 with a program on mental illness.

Again presented by the American Medical Association and Smith, Kline and French Laboratories, "The March of Medicine" will be carried Sunday, October 24, at 5:30 P. M., EST over 60 stations of the National Broadcasting Company's television network.

This telecast will be followed by a special TV report during the Clinical Session of the American



Medical Association in Miami and by other programs in the spring of 1955.

The October telecast will deal with the difficult subject of mental illness, focusing attention principally upon research and advances in treatment of schizophrenia. The program will present authorities in this field and show actual work under way in research laboratories and clinics.

### Society's First Television Program Presented August 23

This studio view of the first of four educational television programs sponsored by the State Medical Society was taken just prior to the telecast from WNHC-TV on August 23. Dr. A. Lewis Shure, seated at left, and Dr. Barnett Greenhouse, both of New Haven, pose for camera angles, while Robert Wakeley, moderator, right, discusses final prepara-

tions. Camera man is Winston Suidor of the studio staff.

Mr. Wakeley is a member of the New Haven staff of the Connecticut Division, American Cancer Society. He served as moderator for the entire "Stay Well" series of thirteen telecasts, which included the Society's four presentations. Physician panelists for the other three programs were Milton M. Lieberthal, Bridgeport; Henry E. Markley, Greenwich; Edwin F. Trautman, Trumbull; Louis Rogol, Danbury; Stewart P. Seigle, Hartford; and Charles E. Jacobson, Jr., of Hartford and Manchester.

The series was sponsored as a public service with WNHC-TV by the Connecticut TV Committee for Health Education, comprising representatives from 15 statewide health agencies and four television stations. Titles for the Society's four productions, each of which sought to present useful infor-





mation to a potential audience of a quarter million viewers, were "Your Medical Care Today;" "How to Help Your Doctor Help You;" "When the Doctor Comes to Your House;" and "When the Patient Needs Special Care."

The fifteen-minute programs were telecast on successive Monday evenings at 6 o'clock. Plans for a second series are now underway.

### New England Health Institute Held in August in Burlington, Vermont

As host to the 20th New England Health Institute the Vermont State Department of Health gave a typically cordial "Vermont" welcome to nearly 500 professional persons working in the New England and nearby States.

The Institute serves traditionally as a "regional school of public health" for a concentrated course crowded into three days. The quest for new public health knowledge and particularly for better methods of applying advances in medical sciences for the improvement of the health of New England people was evident. State borders melted away as many similar problems were found facing all States. Imagine some spicy differences of opinion, with a united approach to problems, in an atmosphere of Vermont hospitality and you have the spirit of "brotherhood for New England's health" which marked the Institute.

A speech by Mr. Harlan L. P. Wendell, representative of the Department of Health, Education and Welfare on the Eisenhower Public Health Program covered five major points, two of which have received support of Congress: namely expansion of hospital construction and expansion of rehabilitation services for the handicapped. Under the hospital construction expansion, New England will receive \$3,618,000. The lack of beds for chronic disease is shown by the fact that in 1950 only 5 per cent of all general hospitals had facilities for care of patients with long-term illness. There were only 50,000 beds available for patients with chronic illness. Each State is to receive \$25,000 to conduct surveys of the needs for new facilities—chronic disease hospitals, nursing homes, etc. The cost of construction of general hospitals is \$16,000 per bed while the cost for nursing or convalescent hospitals is \$13,000 per bed. Moreover the operating cost of a convalescent hospital is only one-third that of a general hospital.

Regarding rehabilitation of the handicapped the expectation is that by 1959 200,000 persons will have been rehabilitated. The program allows for training of physicians and nurses.

#### PHYSICIAN'S OFFICES IDEAL SITE FOR EXAMINATION OF SCHOOL CHILD

Under the title of "Ideal Concepts of Health Services for the School Age Child," a panel of public health workers including a public health nurse, a physician, a sanitary engineer, a nutritionist and safety specialists "painted a picture" of utopian health services for the child of school age. The physician on the panel, Louis Spekter, M.D., director, Bureau of Maternal and Child Hygiene, Connecticut State Department of Health, stated that the best place for the medical examination is the physician's office since the quality of the examination depends upon adequate medical facilities, familiarity with the details of the child's development, acquaintance with the family, and enough time for the examination and for discussion of problems with the parent. To achieve effective community service, participation of all local physicians is necessary. The nutritionist had found that many children have misconceptions regarding health which need correction.

#### NURSING HOME LICENSING

In the discussion of "Public Health Aspects of Nursing Home Licensing" the speakers emphasized many neglected points, some of which were:

1. There is a need for careful handling of all drugs. Drugs should be used only for the patient for whom prescribed; after a patient has left the nursing home, his surplus drugs should either be turned over to proper authorities or destroyed in presence of a witness who signs a statement;
2. It is unfortunate that nursing homes can order barbiturates in large quantities without prescription—especially since these may be misused at night when what would help the patient most would be a nutritious snack;
3. Meal schedules should have more attention because of the attendant's desire to leave on time, thus pushing forward the supper hour to as early as 3:30 P. M. Breakfast is usually not served until 7:30 A. M. Quality, quantity and scheduling of meals are important;
4. The nursing home needs to be run for the comfort of the patients and not for an appearance of order.

## REHABILITATION AND CARE IN CHRONIC ILLNESS

The hour allocated to discussion of "Total Care in Chronic Illness" was insufficient to deal with this subject adequately. The panel pointed out the need for definition of terms. Rehabilitation was stressed as a goal to be achieved through total care. The importance of team work, the role of family physician, public health physician, and social worker, etc., was stressed. When it is difficult to determine whether or not a patient can be rehabilitated, it was suggested that a trial period might be helpful. It was also recognized that motivation is a prime factor in rehabilitation. In the discussion of chronic disease program planning, it was pointed out that all agencies in the community should be active, but that medical problems should be decided by a medical advisory board. As chronic illness produces financial hardships and emotional strain in patients, relatives and society, better ways to cope with its problems must be found.

## LABORATORY SERVICE

During the session related to laboratory services when a worker from each State reported, it became evident that Connecticut offers a larger variety and a greater volume of laboratory services than any other New England State.

## CANCER CONTROL

At the session concerning cancer control, Dr. Herbert Lombard, director, Division of Cancer and Other Chronic Diseases of the Massachusetts Department of Public Health, made a preliminary report of a study which shows that there is a definite correlation between heavy cigarette smoking and lung cancer, but not the same correlation with pipe and cigar smoking. As the New England States reported on their cancer control programs, Connecticut reported a cancer register more comprehensive and useful than now exists in any of the other States represented.

## REPORTING DEATHS

The physicians who attended the session on public health statistics were interested in the discussion regarding the new system for reporting causes of death on death certificates, as the new system has more meaning clinically. This realistic coding of the causes of death, which went into effect in 1949 with

the adoption of the 6th revision of the International Classification of Causes of Death, makes it the responsibility of the physician to report the immediate cause of death and the chain of events which precede the immediate cause. The representative from Connecticut reported that, on the whole, Connecticut physicians seemed to understand how the death certificates are to be made out. Some of the other New England States reported that some physicians are still reporting primary and secondary or contributory causes of death.

## MENTAL HYGIENE SESSION WELL ATTENDED

In the section on mental health, which was better attended than at some previous New England Health Institutes, the discussion started on the question, "Are there any fundamental principles on which we can base community programs for promotion of mental health education?" The answer was "yes." Principles of causation can be applied to behavior as well as to physical symptoms. For example, if a person has a "belly ache," there is a reason for the ache which may or may not be physical. If the basis is emotional rather than physical there is still a cause for the "belly ache."

## ALL PHASES OF COMMUNITY LIFE SHOULD BE CONSIDERED

In an exceptionally fine presentation on "Public Health in Our Society," Benjamin D. Paul, PH.D., anthropologist and lecturer at the Harvard School of Public Health, stressed that public health programs are doomed to failure unless they take into account the three dimensions of community life namely—cultural, social and psychological.

## STATE MEDICAL SOCIETY OFFICIALS ATTEND

The fact that the Executive Secretary, Dr. Creighton Barker, and the President-elect, Dr. Oliver L. Stringfield of the Connecticut State Medical Society attended parts of the Institute, is an indication of the real interest of practicing physicians in public health problems. They, like other physicians of Connecticut are ever preventing disease—and the New England Health Institute was one more meeting place for the exchange of information for the maintenance and improvement of the public health. To us it seemed that Connecticut representatives were second to no other State in the effective and pleasant interchange of ideas at the New England Health Institute.



## Connecticut Committee on Foods, Drugs, Cosmetics and Devices

Meeting of July 29, 1954

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Medical Society, Dr. Hugh Dwyer and President H. M. Marvin; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Barnett Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

### POLIOMYELITIS VACCINE

"The new poliomyelitis vaccine" in the May 27 Report was revised to read as follows:

"Dr. Hart said that newspapers had reported one case of paralysis (not in this State) after use of the Salk vaccine. It was suspected that the patient had mumps."

### LABELLING OF METHYL SALICYLATE

Prof. Fenney remarked that at the May 27 meeting he had questioned whether wholesalers' labels on bottles of methyl salicylate carried proper warnings, but since that time he had found that McKesson & Robbins labels now bore the statement: "Keep out of reach of children."

### INFORMATION SERVICE ON ANTIDOTES FOR COMMON POISONS

At the September 24, 1953 meeting it had been voted that this "subject be tabled until Fisher brought it up again." Dr. Fisher reported that early in June J. H. Johnston, M.D., director of the Bureau of Industrial Hygiene of the State Department of Health, had informed him on the telephone that Dr. Osborn had assigned a new member of his staff, Dr. Mogens Plessen, to complete the list of common household poisons and put it into form (with the Committee's help) for distribution by the Health Department. On June 10 Dr. Plessen called on Dr. Fisher to discuss this question further; Dr. Fisher loaned Dr. Plessen his copies of the "Pesticide Handbook" and Lucas's "Symptoms and Treatment of Acute Poisoning," and it was agreed that Dr. Plessen would prepare the list of products and their active ingredients and turn this list over to Dr. Bonnycastle

for insertion of the suggested antidotes, after which Dr. Fisher would go over the completed copy before returning it to the Health Department for reproduction and distribution.

Dr. Bonnycastle showed the members the list that Dr. Plessen had given him, and made an appointment with Dr. Fisher for July 30 to talk over certain points about this list before he prepared the text on treatments. Dr. Bonnycastle noted that the list was not yet a complete one of all household poisons, but did represent a concrete start; it deliberately omitted all medicines, and failed to include cyanide-containing polishes and stove cleaners (sodium cyanide was mentioned only once).

Dr. Hart remarked that lead poisoning cases among children were always being encountered. He cited one New Haven case of a child's death: This child was excreting a lot of lead, but no paint to which it had access contained over 1.6 per cent of lead. Another case was that of a year and a half old infant who had been sent to Seaside Sanatorium, only to get sick suddenly 16 months later and be transferred to New Haven Hospital, where he died of lead encephalitis. In this case early x-rays had not shown any evidence of lead in the bones (the child came from Hartford originally), and only traces of lead could be found in any paint to which the child had had access at the Sanatorium. There was a third case of a child with lead poisoning where no source for the lead could be detected.

### CARBOHYDRATE IN BEVERAGES

Dr. Greenhouse said he wished to call the members' attention to an article on sorbitol as a sweetening agent in the magazine *Forecast*; this article emphasized that such sorbitol had to be counted as part of the carbohydrate content of the food. Dr. Greenhouse said he was sure that people were using beverages made by Cott and other manufacturers without realizing this—they were consuming a lot of carbohydrate without knowing it. To a question of Dr. Hart as to the relative carbohydrate contents of regular sweetened carbonated beverages and the "dietetic" type, Dr. Greenhouse replied that the "regular" drinks contained about 10 per cent of carbohydrate, while the sorbitol-calcium cyclamate drinks might contain as much as half of this.

### "REAGENT ACTING CREAM"

Mr. Plank called to the members' attention copy for a label and circular submitted by J. M. B. & Co.

of Warehouse Point in connection with a new drug application for a product of the above name. The proposed circular contained the following statements, among others:

(1) "Whereas other creams have the primary function of cleansing the skin, or perhaps forming a protective coating, Reagent is designed to purge the inner as well as the outer epidermis, thus allowing the blood to carry away impurities by normal healthy blood circulation."

(2) "During the first and possibly the second application of Reagent Cream, a slight sensation of tightening of the skin might be noted. This effect is caused by better blood circulation."

After some discussion, it was voted that it be the Committee's opinion that the phrase "Reagent is designed to purge the inner as well as the outer epidermis," as well as the two references to blood circulation, should be deleted.

#### ELECTION OF OFFICERS

Joseph DeVita, V.M.D. was elected chairman and Harry J. Fisher, PH.D. reelected secretary-treasurer for the coming year. On motion of Dr. Bonnycastle, rising votes of thanks were extended to Drs. Dwyer and Fisher for their work during the past year.

### Professional Equipment Burned Out

The Professional Equipment Company, one of the JOURNAL's first advertisers and for many years the occupant of the inside of the front cover each month, sustained a serious loss by fire at its New Haven plant on September 2, the loss running almost to \$100,000. The fire was so severe that five firemen were overcome by smoke, two of them requiring hospitalization.

Professional Equipment has been in business about 40 years serving Connecticut physicians and hospitals. Even though the entire loss was covered by insurance, they will be operating under a handicap for some time. Temporary quarters were set up nearby and within three days substantial replacement stock shipments were arriving from dozens of supply houses. Competitors offered help and several manufacturers furnished men to assist in carrying on business as usual. With the cooperation of the insurance company and the various manufacturers, every single item damaged in any way will be replaced

completely. There will be no possibility of any customer receiving anything but new merchandise.

Professional Equipment is most appreciative of the understanding and patience of customers, expressed in innumerable telephone calls and letters. The JOURNAL adds its word of encouragement to its friends who have been such loyal supporters of our publication in its infant years.

### AMA Establishes New Law Department

The Board of Trustees recently established a new department within the AMA. It will be known as the Law Department. Effective August 1, the Bureau of Legal Medicine and Legislation and all of its records and personnel will be transferred to this newly established department.

Mr. J. W. Holloway, Jr., who has headed the Bureau of Legal Medicine for many years and who is rated as one of the country's leading experts on medicolegal problems, will serve as consultant to the new department.

The Law Department's director will be C. Joseph Stetler, who came with the AMA in March of 1951 as secretary of the Council on National Emergency Medical Service. He received his LL.B. and LL.M. degrees from Columbus University, Washington, D. C., and is a member of the District of Columbia and Illinois Bars.

The staffing of the AMA Committee on Legislation will be provided by the Law Department.

All requests for legal opinions and advice from the various councils, bureaus and departments within the AMA headquarters office will be made directly to the Law Department.

### Winsted Physicians Oversubscribe for Hospital

By contributing a total of \$51,300 toward the building of a new and enlarged Litchfield County Hospital, members of its medical and surgical staff have exceeded their objective of \$50,000 which they set at the beginning of the \$600,000 building campaign early in 1954. Several physicians have selected individual memorial units. Others have designated their subscriptions toward staff memorial units and have chosen the physicians' lounge and library, the physicians' locker room, two waiting rooms, and a children's two bed room.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Newell W. Giles, Darien*

*President-Elect, Mrs. Norman J. Barker, Collinsville*

*First Vice-President, Mrs. J. ALFRED WILSON, Meriden*

*Second Vice-President, Mrs. Frank L. Polito, Torrington*

*Recording Secretary, Mrs. Charles Culotta, Hamden*

*Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob*

*Treasurer, Mrs. Joseph Woodward, New London*

On August 25 Mrs. Creighton Barker attended the New England Health Institute in Burlington, Vermont. Dr. Louis Spekter, director of the Bureau of Maternal and Child Hygiene, Connecticut State Department of Health, spoke on "The Pediatrician Looks at School Health."

Dr. Spekter feels that the pediatrician should be interested in a community program. Primarily he should acquaint himself with the quality of the physical examination given to school children. At this examination the parent should be present and the child should be undressed. The best place for such an examination is the doctor's office, the doctor being the family pediatrician. Tests for vision and hearing, the latter by audiometer, can be given at school.

### County News

#### MIDDLESEX COUNTY

The Connecticut State Medical Society's First Aid Chart received its initial distribution at the Durham 4-H Fair in August. Dr. Norman Gardner, who represents both the national and state medical organizations in rural health, was at the fair booth to answer questions on the material displayed. Mrs. Harold Smith and Mrs. Willard Buckley of Middlefield and Westfield, respectively, staffed the booth. They reported that visitors showed much interest and persons with Scout packs took quantities of the chart.

In Chester, Mrs. D. Leonard Lieberman manned a fair booth. Mrs. Walter Nelson is over-all public relations chairman for the county.

#### NEW LONDON

Mrs. Julian Ely served as chairman for a health education exhibit at the Hamburg Fair in August. A second exhibit was held at the Norwich Grange Fair in Norwichtown.

A benefit bridge and cake sale were held at Lighthouse Inn on October 5. Proceeds will be used for

the Nurses Scholarship and Welfare Fund. Mrs. Frederick Fagan headed the committee which ran this affair.

#### WINDHAM

On September 4, 5 and 6 the county ran a Medical Exhibit at the Woodstock Fair. It was sponsored by the State Medical Society and each of the exhibits was managed by a local committee.

### Medical Education in U. S.

Today's physician population has now reached approximately 220,100, an all time high ratio of one physician for every 730 persons in the United States. The record graduation figures were released in the 54th annual report on medical education in the United States by the American Medical Association's Council on Medical Education and Hospitals.

Highlights of the report:

—Enrollment of 28,227 is largest number of medical students in history of U. S.

—Freshman class enrollment of 7,449 also is a record.

—More than 76 million dollars was spent during 1953-1954 for new facilities, remodeling or completion of buildings for medical instruction.

—Budgets for medical schools during 1954-1955 total more than 143 million dollars.

—21,328 physicians did volunteer teaching without pay during the year.

—Ten new four year schools are in construction or planning stages and will be in operation within the next few years.

The ten new four year medical schools will be at the Universities of California, Mississippi, Miami, Missouri, Florida, West Virginia, Kentucky, North Dakota and Yeshiva University of New York and Seton Hall University. In addition, three other medical schools are being considered.

OBITUARY

Paul A. Park, M.D.  
1884 - 1954



Dr. Paul A. Park, 70, of Crestwood Road, Fairfield, Connecticut, a general practitioner and obstetrician in Bristol for over 30 years, died suddenly during August at Bridgeport Hospital after a short illness. Dr. Park was born in Cedar Rapids, Iowa, on July 21, 1884 and was a graduate of Iowa State University and Medical School.

He practiced in Iowa for some years and came to Bristol in 1919, residing there until his retirement in 1950. At the time of his retirement he was chief of obstetrics at the Bristol Hospital. During the course of his career as an obstetrician Dr. Park estimated he had brought into the world over 4,000 babies. During his years in Bristol he was regarded by his professional colleagues and by the public as the ideal family physician. Paul Park just couldn't turn down a call regardless of the time of day or night or how tired and exhausted he may have been. During World War II with Bristol short of doctors he carried a terrific load which finally made it necessary for him to retire. On moving to Fairfield, Dr. Park supervised visits of the Bloodmobile to that town for the

past three years. He was a member of the First Church of Christ, Congregational, in Fairfield. Dr. Park was a member and past president of the Bristol Medical Society, an active member of the Hartford County Medical Association and of the State Medical Society. He is survived by his wife, two daughters, a grandson and granddaughter.

He was as fine a man as I have ever known.

H. B. Woodward, M.D.

Connecticut Taxes

We are indebted to *Connecticut Industry* for the following Connecticut tax figures. Total tax bill paid in Connecticut (in millions):

1937	1947	1952
\$199	\$831	\$1,408

Total taxes collected in 1952 for Federal Government (in millions); \$1,100.3 (78.2 per cent).

Taxes remaining for State and local use (in millions): \$308.4 (21.8 per cent).

Alfalfa Seed Tea

William H. Kaufman of Bridgeport has reported on two cases of skin trouble from drinking alfalfa seed tea in the July 17 *Journal of the American Medical Association*. He said he knows of no previous reports of skin trouble from alfalfa seed.

"The practice of taking alfalfa seed for the purpose of relieving arthritis, diabetes, and related disorders is apparently widespread," he said, "and there is a strong likelihood that further cases will appear."

He said two patients suffered skin eruptions as a result of the remedy and that four other possible cases have been found. One of his two patients, an elderly woman, said she had concealed the fact that she drank the tea because she was "ashamed to admit it." The other admitted "with great reluctance" that she used the tea.

The Council on Pharmacy and Chemistry of the AMA reports there is no evidence that alfalfa seed in any form will help.



## SPECIAL NOTICES

### HARTFORD HOSPITAL GUEST SPEAKER PROGRAM

Saturdays, 11 A. M., Amphitheater  
October through December 1954

October 2

S. J. Thannhauser, M.D., emeritus professor of medicine, Tufts College Medical School; Case presentation

October 9

Dorothy M. Horstman, M.D., associate professor of preventive medicine, Yale University School of Medicine  
Problems in the Prevention of Poliomyelitis  
Third Dwight Griswold Memorial Lecture

October 16

Albert H. Aldridge, M.D., chief, Woman's Hospital, New York City; clinical professor of obstetrics and gynecology, Columbia College of Physicians and Surgeons  
10 A.M. Stress Incontinence  
11 A.M. Medical and Surgical Aspects of 1,500 Abdominal Hysterectomies (Aldridge technic)

October 23

No guest speaker clinic at Hartford Hospital. All interested physicians invited to American College of Physicians meetings at Hotel Statler, 9:30 A. M. to 12 noon

October 30

Maurice S. Segal, M.D., clinical professor of medicine, Tufts College Medical School  
The Hazards of ACTH Administration in Patients With Pulmonary Disease

November 6

Charles M. Fisher, M.D., associate neurologist, Massachusetts General Hospital  
Cerebral Vaso-Spasm

November 13

Howard B. Sprague, M.D., physician, Massachusetts General Hospital; clinical associate in medicine, Harvard Medical School  
Coronary Artery Disease in the Young Adult Male

November 20

Harry S. N. Greene, M.D., professor of pathology, Yale University School of Medicine  
Virus-Tumor Relationships

November 27

Mark A. Hayes, M.D., associate professor of surgery, Yale University School of Medicine  
An Energy Evaluation in Postgastrectomy Syndrome; A Dietary Approach to Treatment

December 4

John R. Brooks, M.D., instructor in surgery, Harvard Medical School  
Postoperative Pancreatitis

December 11

Averill A. Liebow, M.D., professor of pathology and clinical pathologist, Yale University School of Medicine  
Clinical Pathological Conference

December 18

Irving A. Beck, M.D., Providence, R. I.  
Interstitial Pneumonia With Eosinophilia

December 25

No clinic

January 1

No clinic

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

October 7

The Unknown Murderer: Considerations of the Unconscious Etiologic Factor in Medicine  
Stephen H. Sherman, M.D.

October 14

Case Presentation: Addison's Disease  
Julius J. Sachs, M.D.

October 21

Clinicopathological Conference  
Paul M. Sherwood, M.D., moderator  
Annual Dinner Meeting 6:30 P. M.  
Hotel Statler, Hartford

Guest Speaker: Dr. Alex M. Burgess, Providence  
Topic: "Boards and Shingles"

October 28

Civil Service Retirement Benefits For Physicians  
Albert Baskerville, personnel officer, Veterans Administration, Hartford

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference room. All interested physicians are cordially invited to attend.

### GASTROENTEROLOGICAL CONVENTION

The Nineteenth Annual Convention of the National Gastroenterological Association and the First Annual Convention of the American College of Gastroenterology will

be held at The Shoreham in Washington, D. C., on October 25, 26 and 27, 1954.

In addition to several interesting individual papers on gastroenterology and allied fields, the program will include a panel discussion on "Twenty-Five Years' Observation of the Gallbladder Controversy;" a panel discussion on "Amebiasis" by members of the staff of the National Institutes of Health, Bethesda, Maryland, and a symposium on "Esophageal Varices."

The Sixth Annual Course in Postgraduate Gastroenterology, under the personal direction of Dr. Owen H. Wangenstein of Minneapolis, Minnesota, and Dr. I. Snapper of Brooklyn, N. Y., will be given on October 28, 29 and 30, 1954 at The Shoreham and Walter Reed Army Hospital. Participating in giving the Course will be a distinguished faculty from the various medical schools and the staff of Walter Reed Army Hospital.

This will be the last Convention of the National Gastroenterological Association whose Fellowship have voted to become the American College of Gastroenterology.

The scientific sessions on October 25, 26 and 27 are open to all physicians without charge. The Postgraduate Course will only be open to those who have matriculated in advance.

Copies of the program and further information concerning the Postgraduate Course may be obtained by writing to: National Gastroenterological Association, 33 West 60th Street, New York 23, N. Y.

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#### 7th PR CONFERENCE TO BE HELD IN MIAMI

Public relations tips "for doctors only" will be presented at AMA's Seventh National Medical Public Relations Conference to be held in Miami Sunday, November 28, the day preceding the opening of the Clinical Session.

The program at the McAllister Hotel will be geared primarily for physicians, offering suggestions on ways to improve the medical profession's public relations at the grass roots level. Members of the House of Delegates, officers of state and county medical societies, executives and PR personnel are cordially invited.

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#### Define Officers' Membership in AMA

At the AMA San Francisco meeting a resolution was introduced, requesting that reserve officers of the United States Public Health Service who are on active duty be given service membership in the AMA. The resolution was referred to the Board of Trustees, which has since ruled that:

"Reserve medical officers of the United States Public Health Service on active duty are to be given the same consideration as that extended to reserve medical officers on active duty with the military forces. In other words, those officers will be exempted from payment of dues for the perior begin-

ning January 1 or July 1 following the date of the member's entrance into the service."

All such officers who hold a type of membership in the constituent medical association that permits them to vote and hold office will be eligible to hold active membership in the AMA and be excused from the payment of dues. It will be necessary, therefore, for their names to be forwarded through their constituent medical society to AMA headquarters with the request for exemption from the payment of AMA dues. During the period for which they are exempted, they are not entitled to receive *The Journal of the American Medical Association* as a benefit of membership, but may subscribe to it, or other AMA publications. Such officers will be given active membership in the AMA and not service membership.

Service members are regular full-time medical officers in the Army, Navy, Air Force, U. S. Public Health Service, Veterans Administration, and Indian Service, and are not required to hold membership in a component and constituent association.

#### Postgraduate Courses

Nearly one hundred lecturers and demonstrators are scheduled to take part in the courses the Eighth Postgraduate Seminar in Psychiatry and Neurology and the Postgraduate course in the Management of Chronic Pulmonary Disease to be held during the coming months at the Yale Medical School.

The Seminar in Psychiatry is sponsored by the State Department of Mental Health and the Department of Psychiatry of the Yale Medical School and offers a unique and valuable educational opportunity to the physicians of Connecticut. The formal teaching sessions at the Medical School will be supplemented by staff conferences and demonstrations at ten hospitals and schools in the State. The course in pulmonary disease will consist of eight weekly conferences at the Medical School and has been arranged by the division of Postgraduate Medical Education.

The content of both of these courses is particularly for general practitioners who are most often the first to see evidences of these disease. These well established postgraduate teaching organizations, like the Clinical Congress, are additional evidence of the wholesome and progressive environment in which medical practice thrives in Connecticut.



## Connecticut Project — Cornell Automotive Crash Injury Research

The Connecticut Project of the Automotive Crash Injury Research under the supervision of Cornell University Medical College, which has been operating in Tolland County will be extended, commencing about November 1 to New London County. This important investigation of injury causing elements of pleasure automobile structure is carried on jointly by the Connecticut State Police and the Connecticut State Medical Society, under the direction of the research group of Cornell Medical College. The physicians and hospitals in New London County will be asked to cooperate in the same way as their neighbors in Tolland County, who have done an extraordinary job during the past three months. The project has been approved by the Council of the State Medical Society and its details worked out by a special committee of which Harold A. Bergendahl of Norwich is Chairman and George Crawford, Centerbrook; Brae Rafferty, Willimantic; Paul W. Vestal, New Haven; Creighton Barker, New Haven are members. Professor Ira V. Hiscock of the Department of Public Health, an Associate Member of the Society represents the Yale Medical School on the committee. Mr. Hugh DeHaven, a resident of Lyme is the Director of the Study for Cornell and other Cornell personnel engaged in Connecticut are: John Moore, Robert Tracy and Richard Braisted. Lt. Leslie W. Williams of the State Police directs the police participation representing Commissioner John C. Kelly.

This important and original research is being carried on simultaneously with the aid of state medical societies in Maryland, North Carolina and Virginia, and a new program will soon get underway in Minnesota. In the study an entirely new viewpoint has evolved. It is recognized that, human nature being what it is, crashes will occur as long as vehicles are driven by human beings, but that it should be possible to make the inevitable accidents productive of fewer crippling or fatal injuries. To this end, highway accidents are analyzed with a view to learning how to build more safety factors into automobiles. Already some highly interesting findings have resulted and as the statistics increase, it is believed that recommendations for revision of details can be made in automobile design.

Physicians and highway police who have engaged in the study have found it stimulating and productive. It cannot be definitely stated how long the

program will continue in the New London area. It will depend somewhat upon the type and frequency of accidents. Finally, the plan will be to present data on a cross section of accident incidence on the highways of Connecticut.

## Survival Under Atomic Attack in Hartford

A result of the survey following Hartford's participation in the nationwide federal civil defense exercise in June revealed some very startling facts. The ratio of those requiring help to those able to give it is so tremendous as to be almost beyond belief, according to the *Bulletin* of the City Board of Health. It is estimated that there would have been but five physicians available to look after 4,500 civilian casualties, or one physician for every 900. Only four of Hartford's fixed medical installations would have survived the blast, leaving the city with not more than about 1,100 beds available for emergency purposes.

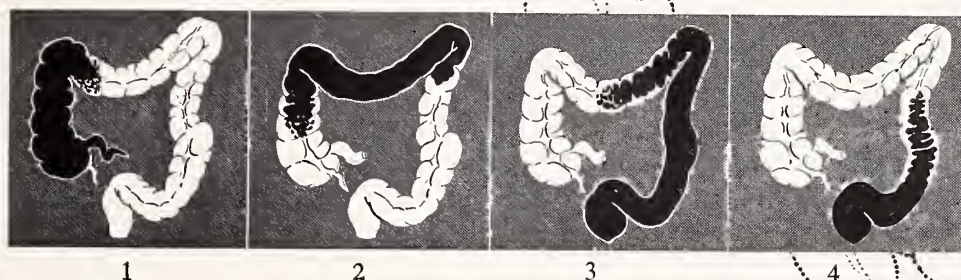
To quote the *Bulletin*: "From a statistical standpoint this exercise demonstrates the futility in believing that Hartford's own medical services would have been of any real assistance in coping with a catastrophe of this magnitude (an atomic bomb of a T.N.T. equivalent of 40,000 tons). It is very doubtful that by even enlisting the services of the remaining 3,900 doctors, dentists and nurses within the Hartford Target Area, the situation could have been very materially improved. From this the assumption is drawn that if Hartford were hit by a  $2\frac{1}{2} \times$  atomic bomb in the downtown area, mutual aid, to be effective, would have to be organized on a very extensive scale and encompass most of the facilities and practically all of the medical services available in the State of Connecticut."

## Two Members on Government Committee

Theodore Klumpp, president of Winthrop Stearns, Inc., and Albert W. Snoke, director of Grace-New Haven Hospital, both members of the Connecticut State Medical Society, have been appointed by the Commission on Intergovernmental Relations to a 13 member study group. This group, headed by Chancellor Murphy of the University of Kansas, will investigate federal grants to state and local governments for public health and hospital projects. The committee has a man sized task which must be accomplished by October 1954, when it will be expected to come up with recommendations as to the continuance, abolishment or modification of this large portfolio of grants.

*Roentgenographic pattern of colon mass propulsion:*<sup>1</sup>

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



## Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*<sup>2</sup>

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

### *Factors Contributing to Chronic Constipation*

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.<sup>2</sup>

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass

after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

### *Dosage Considerations*

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: *A Method of Improving Function of the Bowel*, *Gastroenterology* 13:275 (Oct.) 1949.



## OUR NEIGHBORS

### Rhode Island's New Compensation Law

On July 1, 1954 the revised workmen's compensation law enacted by the general assembly at its recent session went into effect. It is anticipated that this new law will improve the operation of this important program to assist the injured workman.

A brief summary of the major changes in the medical care sections follows:

(1) The maximum allowance for services and medicines, exclusive of hospital services, is increased from \$500 to \$600 in the case of an employee hospitalized for more than 14 days.

(2) Any dispute regarding the reasonableness of the amount of any charge for services or medicine shall be determined by the commission after hearing, and its decision shall be final, if supported by a majority of the medical advisory committee.

(3) The physician's written notice that he is treating a workmen's compensation beneficiary is to be filed within 15 days, instead of 7 as now required, but in addition the new law stipulates that every two months thereafter while the treatment continues a written progress report must be sent to the employer and a bill for services to date, and further, he must present his final bill for all unpaid services within three months after the conclusion of services.

(4) The impartial examiner no longer will have to send a copy of his report to the employee, as the employer or carrier must do that now upon receiving the medical report.

(5) The impartial examiner's report must be filed within 96 hours of the completion of each and every examination.

(6) The impartial examiner may be summoned for the purpose of cross examination by the commission.

(7) A medical advisory committee of seven physicians is to be appointed by the governor to serve without compensation for staggered terms to assist the department of labor and the commission. Three physicians will serve until March, 1955, two until March, 1956, and two until March, 1957, and thereafter appointments annually to fill the vacancies.

(8) Every case of total disability or severe permanent partial disability on which compensation has been paid for a year will be reviewed and such

action taken by the director of labor or the commission, with the advice of the medical advisory committee, as shall seem practicable and likely to speed recovery.

(9) With the advice of the medical advisory committee the director of labor has the authority to prescribe a special report for back injuries, and to recommend specific tests to be performed in the diagnosis and treatment of such back injury, with the recommendation and approval of the employee's physician.

One of the most important features in the revised program is the setting up of a medical advisory committee, serving without compensation. It is expected that this committee will be in a position to develop medical criteria for the determination of causal relationship between injury, disease and disability that will be of great assistance to physicians engaged in the practice of industrial medicine in Rhode Island.

## NEWS

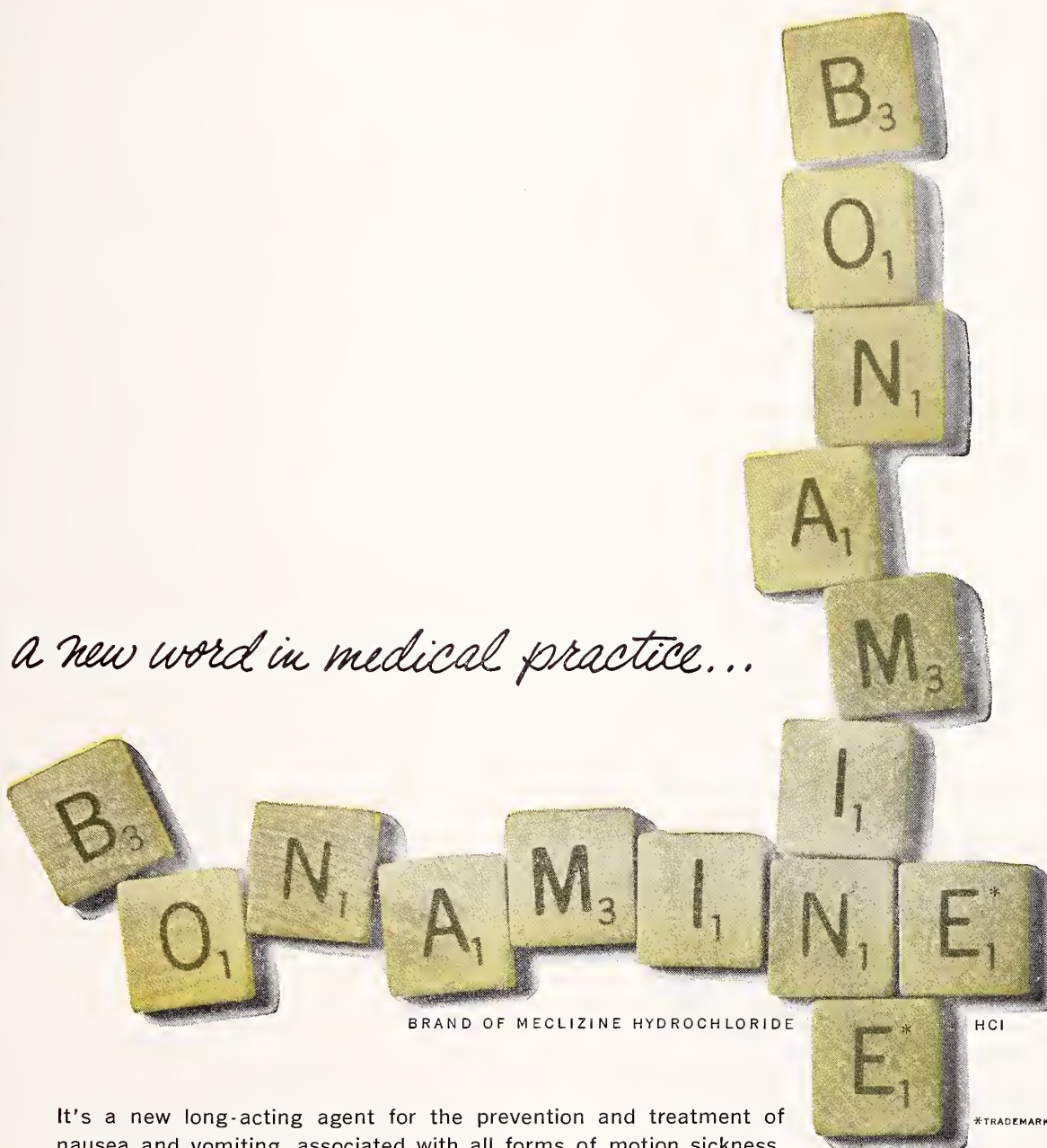
### *from County Associations*

#### Hartford

The medical examiner of Suffolk County, Massachusetts, Dr. Richard Ford, will be guest speaker at the Hartford County Medical Association's semi-annual meeting in Manchester this October 26. Dr. Ford is head of the Department of Legal Medicine at Harvard Medical School.

A meeting of Hartford County Medical Association's officers with Hartford County Polio representatives is in the works to discuss fees and care of polio patients, now that these patients are being received and treated in general hospitals.

Only 364 physicians returned their Blue Cross questionnaire for comprehensive coverage out of 881 receiving them. Of the 364, 14 had the coverage elsewhere, 67 indicated that they did not want comprehensive protection and 283 were in favor of the plan. Because the plan is offered on a group basis and because there must be at least 75 per cent of the group willing to underwrite this type of policy, Hartford County Medical Association members can now have only the standard plan which provides \$9 per day as against the \$12 per day of the compre-



It's a new long-acting agent for the prevention and treatment of nausea and vomiting, associated with all forms of motion sickness, radiation therapy, vestibular and labyrinthine disturbances, and Ménière's syndrome.

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A preliminary tabulation of the first returns of a physicians' survey sent out by the Hartford County Medical Association revealed that over 170,000 hours of free medical services are contributed annually to Hartford County residents as a community service by the medical profession.

Dr. Amos E. Friend, president of the County Medical Association, said that the physicians' survey was undertaken to determine some of the habits of Hartford County doctors, such as the number of hours worked, percentage of patient loads carried in each specialty and services given to patients without reimbursement for time or effort. "We were particularly interested in the total number of hours donated by our members to persons who were unable to pay for services rendered. This includes clinic and some office service, and hospital care both in the wards and outpatient departments of all general hospitals in the county and for ward and medical service for indigent patients at McCook Memorial Hospital."

The survey indicated that of those who gave free time the average number of hours contributed by the family physician was almost five per week. This was about eight per cent of his working week. He averages 64 hours working time.

Specialists other than surgeons who donated their services averaged slightly better than four and three-quarters of free time per individual in any week. The average work week for this category was 49½ hours of which 9½ per cent were given without charge.

Surgeons contributed the most uncharged time with an average per physician of close to seven and one-half hours per week. Surgeons donating service averaged 13 per cent of their working week of 56¼ hours.

"Other specialists (radiologists, pathologists, anesthesiologists) gave six hours per week per physician. Average estimated percentage per doctor giving free time was 11 per cent out of a work week of 50¼ hours.

Total uncharged time per category per week was: family physicians, 586 hours; surgeons, 1,744 hours; specialists other than surgeons, 926 hours and "other" specialties, 192 hours.

Louis Spektor, director of the Connecticut State Department of Health's Bureau of Maternal and Child Hygiene, discussed "The Pediatrician Looks at School Health Services" at the 20th New England Health Institute held at the University of Vermont on August 25.

## CONNECTICUT AMBULANCE ASSOCIATION

Emergency Hospital - - - - Bridgeport  
Nelson Ambulance Service - - Bridgeport  
Dunn Ambulance Service - - - - Bristol  
Maynard Ambulance Service East Hartford  
Aetna Ambulance Service - - - Hartford  
Maple Hill Ambulance Service - Hartford  
Kamen's Ambulance Service - - Meriden  
Chamberlain Ambulance Service - Milford  
New Britain Ambulance Service New Britain  
Flanagan Ambulance Service, Inc. New Haven  
Union-Lyceum Ambulance Service

New London

Fairfield Oxy. & Amb. Service - Stamford  
Academy Ambulance Service - - Stratford  
Campion Ambulance Service - Waterbury  
Fitzgerald's Ambulance Service Waterbury  
Waterbury Hospital - - - - Waterbury

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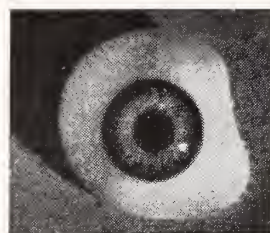
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## Middlesex

William F. Bauer, who interned at Middlesex Hospital about four years ago and then did general practice in Middletown, closed his office and on September 1 began a residency in anesthesiology at Hartford Hospital.

Christie McLeod attended the International Congress of Pathology in Washington, D. C., the first week in September.

Mario Palmieri is again becoming the fulltime health officer for the city of Middletown. He held this position from 1937 until 1945. Between then and now he has been engaged in general practice.

Two doctors have recently opened offices in Middletown. Donn C. Barton is in general practice and Anton Lethin, Jr., is limiting himself to pediatrics.

## New Haven

The medical staff of Griffin Hospital, Derby, voted to inaugurate a fact-finding health survey as the first step toward the establishment of a district department of health. The presence of twenty-four potential paratyphoid carriers in the community calls for immediate action as a preventive measure.

Barnett Greenhouse of New Haven has been appointed Governor of the American Diabetes Association for the State of Connecticut.

Lewis G. Beardsley, director of the West Haven Veterans Hospital, received an award for a "useful, productive life in public welfare" at the annual meeting and reunion of the Gaylord League at the Gaylord Farm Sanatorium on September 25. The award is known as the David A. Lyman medal. This is the second time the Lyman medal has been awarded, William H. Morriss of Gaylord being the first recipient in 1953.

## New London

It has recently been announced by the Yale Medical School that Paul Gerity, M.D. has been appointed clinical instructor in surgery. He will continue to have his office in New London.

William J. Murray, Jr., M.D. has been appointed county chairman for the Diabetic Detection Drive in November.

Charles F. Dyer, M.D. announces the opening of his office for the practice of general surgery at 302 State Street, New London.

Robert Haines, M.D. announces the opening of his office for the practice of ophthalmology at 302 State Street, New London.

The semi-annual meeting of the New London County Medical Association will be held on Thursday, October 7 at Uncas-on-the-Thames. The business meeting will be followed by dinner and a scientific session. The speaker will be Arthur Thibodeau, professor of orthopedics at Tufts Medical School and visiting orthopedist at the New England Medical Center Hospital, Boston. His subject will be "Low Back Pain With Evaluation of the Present Status of ACTH and Cortisone in Orthopedics."

NEW BOOKS IN REVIEW

*THE PHYSICIAN AND HIS PRACTICE.* By Eighteen authorities. Edited by Joseph Garland, M.D., Editor, *The New England Journal of Medicine.* Boston: Little Brown & Co. 1954. 270 pp. \$5.

Reviewed by STANLEY B. WELD


The distinguished editor of *The New England Journal of Medicine* continues to carry aloft the intellectual torch of medical journalism which prevents our state and sectional publications from becoming the mundane reporters of medical society events and the second rate scientific reviewers, a role they could so readily occupy. Readers of Dr. Garland's journalistic pages are feasted weekly from his seemingly limitless store of scientific and historical knowledge, enhanced by an understanding of English and American literature to tempt the most reluctant. It is no surprise then to find him turning to the production of a book which supplies a fund of information regarding the physician's career. Even though the editor claims it is not a detailed guide for the young doctor starting out in practice, yet it contains a wealth of information which should be invaluable to the beginner in the science and art of medicine. For the older practitioner as well there is much to commend it since these are days of rapid shifting in economic emphasis.

It would be difficult to think of a subject related to medical practice which is not covered in this volume. Group practice, specialization, the doctor's family and community relations, the doctor's wife, his relation to his hospital, the business side of medicine including office equipment, insurance, drugs, laboratory facilities, medical reading and writing, and legal medicine—these are some of the subjects included. Each chapter is written by an expert in his field and the list comprises not only physicians but a graduate nurse, a director of purchasing in one of our university medical centers, a professional management consultant, two members of the legal profession, and one who is both a physician and a lawyer. Eminent among these are the president of the American Medical Association, a past president of the American Academy of General Practice, and a member of the United States Supreme Court.

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**NEW AND NON OFFICIAL REMEDIES—1954.** Accepted by the Council on Pharmacy and Chemistry. Philadelphia: J. B. Lippincott Co. 1954. 609 pp.

Reviewed by STANLEY B. WELD

This book issued annually under the direction and supervision of the Council on Pharmacy and Chemistry of the AMA provides the physician with such information concerning the actions, usage, limitations and dosage of acceptable and relatively new drugs as will promote the practice of rational therapeutics. The present volume presents several changes from those of previous years. Whereas it formerly consisted of two sections, one containing general statements and monographs describing actions, usages and dosages of various drugs, the other containing tests and standards for Council accepted drugs for which official standards are not available, now it contains only former Section One. The material in former Section Two is now published less frequently in a separate volume.

The section entitled Bibliography of Unaccepted Products has been omitted from the 1954 volume for various reasons. There has been added a list of drugs omitted since the previous edition and a list of the new drugs added. Few physicians have any conception of the amount of work required of the Council on Pharmacy and Chemistry in this day of an ever increasing pharmaceutical industry. The Council is making a real effort to provide the physician with up to date information on new drugs. If New and Non Official Remedies does not afford the information desired, requests sent directly to the secretary of the Council at AMA headquarters will be given prompt attention.

Every practicing physician should have at hand a copy of this valuable book.

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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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## ANTIBIOTICS

### Their Clinical Use in the Management of Infections

IVAN L. BENNETT, JR., M.D., *Baltimore*

#### INTRODUCTION

Three hundred and sixty-three days ago, at the 28th Connecticut Clinical Congress, there was held in this very room a symposium at which the prophylactic use of antibiotics and the complications of antibiotic therapy were discussed. During the evening before that symposium, pediatricians in attendance at the Congress had heard a special lecture on the antibiotic treatment of infections. This morning, before the present session is ended, another section of this 29th Congress will hear a lecture on the gastrointestinal complications of antibiotic therapy. This programming is in no way unique; I mention it only as evidence that discussion of antibiotics bids fair to become a favorite indoor sport of the medical profession.

It is platitudinous to say that antibiotics have changed medical practice. Deaths from acute infections have decreased phenomenally, such scourges as syphilis and tuberculosis are now curable, epidemics and complications can be controlled by proper prophylactic administration of these agents, and tremendous advances in surgery and many other fields have been rendered possible by their use. This antibiotic era, the age of the "wonder drugs," is indeed a golden time in medicine. Why then so many symposia, lectures and panel discussions? It is clear that the widespread use of specific antimicrobial therapy has introduced new problems into medicine along with its obvious benefits. As drugs and combinations of drugs active against a wider range of organisms have been introduced, resistant variants of some common pathogenic bacteria have appeared, new clinical syndromes attributable to alterations in normal flora or to direct toxic effects and hypersensitivity reactions produced by antibiotics are

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The Author. *Associate Professor of Medicine, The Johns Hopkins Medical School*

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#### SUMMARY

"The antibiotic problem" as it presents itself today is discussed and the various factors involved are outlined. From a beginning with sulfonamides and penicillin, antibiotics have now become a big business. The terminology is confused; the literature is endless. Antagonism, synergism and drug reactions, not to mention public pressure have added to the physician's difficulties.

The three important considerations in the choice of antibiotics are the type of infection, the etiologic agent, and certain characteristics of the individual drugs. The physician must know the patterns of response to be expected from the administration of the various antibiotics. The prophylactic trial has its place but not as a mere shotgun. Prophylactic use of antibiotics is a reasonable procedure under certain conditions. Antibiotics should not be used to replace careful medical methods or surgical procedures. They are often valuable as purely supportive to surgical treatment. The local use of antibiotics has its place with a limited number in certain instances. The incidence of "superinfection" is greater than has been realized.

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becoming common, and a host of new and worrisome terms such as "superinfection," "antagonism," "sensitivity test," etc., have been introduced into the vocabulary of medicine. Let us examine briefly some of the factors to be reckoned with in considering what is now generally referred to as "the antibiotic problem."

1. At the dawn of this era, the physician's new

*Presented before the 29th Connecticut Clinical Congress, New Haven, September 15, 1954*



armamentarium consisted of the sulfonamides and penicillin. The spectrum of activity of these was clear cut; indications for treatment were relatively straightforward. The introduction of streptomycin complicated the picture and as successive agents were tried, accepted, and widely marketed, a multiplicity of potent drugs with antibacterial activities that overlap became available. There are now so many weapons in the arsenal that the "antibiotic of choice" has become an all-important, confusing, changing issue.

2. Antibiotics are big business. Without quoting the number of tons of the various agents being manufactured and sold each month or attempting to estimate what proportion of the nation's annual drug bill is accounted for by antibiotics,<sup>1</sup> I turn to the physician's mailbox for evidence. He is exposed to a seemingly endless bombardment of letters, folders, notices, blotters, pamphlets, reprints and brochures, each hailing some new drug, some new combination, some new dosage form or route of administration, some more palatable vehicle, or some more convenient disposable mechanism for injection.

3. As is unfortunately the case in many rapidly developing medical fields, terminology is becoming well nigh hopelessly confused. Chloromycetin is chloramphenicol, chlortetracycline is aureomycin, and oxytetracycline is terramycin, but tetracycline is achromycin or tetracycline and one must ask for ilotycin or erythrocin if he wants erythromycin. Without belaboring the confusion of trade names, popular names, and "official" terminology, I will simply mention that there is available one commercial preparation of neomycin and bacitracin for local application called Mycitracin and another called Bacimycin. A glance at the advertisements in any current medical journal will amply confirm this state of affairs.

4. If we turn to what might be called the "legitimate medical literature," we find it enormous, massive, vast, and colossal. The bibliography on aureomycin alone now runs to more than 4,000 separate titles. This of course includes abstracts, letters to editors, preliminary reports, confirmatory reports, conflicting reports, editorials, uncontrolled "series," premature pronouncements, and many pure laboratory experiments which do not now and may never have application to human disease. (I do not mean to decry publication of experimental results, only the common tendency to generalize immediately and to transfer results of test tube or animal experiments

to the clinic wholesale and uncritically). To read all these publications, much less evaluate them, is beyond the full-time medical "scholar." For the practicing physicians it is out of the question.

Out of this literature, however, there have emerged and will undoubtedly continue to emerge important and valid findings. Some drugs which showed promise in the laboratory have been tried and discarded because of ineffectiveness in human disease. Certain combinations of antibiotics (e.g., aureomycin and streptomycin in brucellosis) and certain dosage schedules (e.g., streptomycin twice weekly in tuberculosis) have been shown to be beneficial. The importance of resistant strains of bacteria and of the laboratory determination of sensitivity to antibiotics, particularly in staphylococcal and Gram negative bacillary infections, has been established. Lastly, it has come to be recognized that antibiotics are not harmless drugs to be prescribed indiscriminately without proper clinical indication. Hypersensitivity reactions pose a real threat to the usefulness of antibiotics in a sizeable segment of the population. Although the first antibiotic, penicillin, possesses essentially no direct toxicity for man, the same is not true for newer agents. From streptomycin to tetracycline, dosage is limited sharply by toxic reactions and several potent drugs are relegated to limited use or as heroic measures by this factor alone.<sup>2</sup>

As a result, instead of a feeling of security in these mighty new weapons against disease, the average physician often finds himself with a sense of discomfort, worry and frustration over possible use of the wrong drug or failure to use a recently reported effective combination, possible antagonism if two or more antibiotics are administered simultaneously, and the dilemma of prophylactic use in certain situations where the patient may have a drug reaction more serious than the potential infection. There is also public pressure for the use of antibiotics. This is more likely to take the form of demanding quick results than a specific drug. The laity has become so accustomed to the effectiveness of antibiotics that the physician managing illness in the home is likely to be criticized severely if defervescence does not occur within 48 hours and he has not exhibited one of the wonder drugs.

It is no longer possible to tabulate in a simple chart infections, infecting agents and antibiotics. However, as clinical experience with these agents matures and as interest in the pathogenesis of infec-

tion and the host-parasite relationship is renewed, it becomes evident that certain basic principles apply to the use of antibiotics in the management of infections. It is the purpose of this presentation to discuss some of these principles in an attempt to formulate, if such is now possible, a rational basis for antibiotic therapy and to define its place in the present-day management of infections. Specific infections will be discussed only as they exemplify broader principles.

#### CHOICE OF TREATMENT

Among the several factors influencing the choice of an antibiotic to be used in treating any infection are the routes of administration feasible in the individual patient (for example, oral medication would be ineffective if vomiting is a prominent feature of the illness), past history of hypersensitivity or undue toxic reaction to an antibiotic, and, of course, expense, which varies greatly among the individual drugs and dosage forms. Assuming that none of these is a source of significant difficulty, there remain three important considerations: the type of infection, the etiologic agent, and certain characteristics of the individual drugs.

#### THE TYPE OF INFECTION

Often of more importance than the specific etiologic agent is the anatomic location of an infectious process. This aspect of the problem of antibiotic choice is so often neglected that it will be discussed here before specific bacteriologic findings are mentioned.

It is first necessary to recall that antibiotics fall into two groups, the bactericidal which are able to kill microbes outright and the bacteriostatic which inhibit growth and multiplication but are not actually lethal. The commonly used bactericidal agents are penicillin, streptomycin and bacitracin; the sulfonamides and the "broad-spectrum" drugs are predominantly bacteriostatic. It is important to realize that sensitivity tests as ordinarily performed, i.e., by the disk or tube dilution method, measure only inhibition of growth and not killing power, the demonstration of which involves a considerably more complex procedure.

It is now clear that the effectiveness of bacteriostatic drugs in aiding recovery from infection is dependent upon the patient's ability to make a contribution to his own defense. The final extermination of the invader becomes the task of the host's natural mechanisms for resisting infection. Host resistance

is probably a combination of many factors, specific and nonspecific, humoral and cellular, and our lack of knowledge concerning many of them is painful. However, the extensive studies of Dr. Barry Wood on the role of the polymorphonuclear leukocyte in recovery from acute infections have done much to clarify one important aspect of host defense.<sup>3</sup> Briefly, Dr. Wood became curious as to how the purely bacteriostatic action of sulfonamides aided recovery in pneumococcal pneumonia before the appearance of specific antibody. It had been held for many years that phagocytosis of virulent pneumococci could not occur in the absence of antibody, so-called opsonins. Dr. Wood showed clearly that engulfment of pneumococci occurs in the diseased lung before the immune response and then demonstrated that the long-standing idea that this does not occur was a result of the common laboratory practice of assaying phagocytic ability by mixing relatively small numbers of leukocytes and bacteria in test tubes or on glass slides. It was found that rough surfaces such as a fibrin clot, ordinary filter paper, or a thin slice of fresh tissue enabled leukocytes to crawl about rather than float and to trap and engulf bacteria by a process now referred to as "surface phagocytosis." This mechanism is completely independent of any increased stickiness of bacteria due to specific opsonins. The phenomenon of surface phagocytosis has been demonstrated with several species of bacteria both in vitro and in vivo and there can be no great question about the significant role of this type of cellular defense in resistance to acute infections. When the multiplication of bacteria has been halted by a bacteriostatic drug, the granulocytes of the host are able to move about in the fibrin network and debris of the inflammatory exudate and "mop up" the suppressed invaders in an almost leisurely fashion.

How do these findings relate to the original question of the importance of anatomic location in the choice of an antibiotic? Conditions favorable for surface phagocytosis are not equally present in all tissues of the body. Particularly in open cavities, the peritoneum, the pleural spaces, the pericardium, the meninges, or any focus of suppuration and tissue destruction with abscess formation, there is accumulation of fluid, dilution of phagocytes and decrease in opportunities for contact with bacteria, and the granulocytes are deprived of rough tissue surfaces upon which to operate. It is reasonable then to suppose that in these circumstances the host's con-



tribution to defense may be impaired or, indeed, lacking altogether. Bacteriostasis alone cannot eradicate the process and only the ability of an antibiotic to exert direct killing power can assure recovery.

It is also of course necessary that any antimicrobial drug, bacteriostatic or bactericidal, achieve contact with bacteria in adequate concentration to exert its expected effect. The diffusion of chemotherapeutic agents from the blood stream into localized collections of pus is poor. Furthermore the action of sulfonamides is as effectively inhibited by the presence of an accumulation of exudate and necrotic debris as by para-aminobenzoic acid. In such situations antibiotics are no substitute for proper surgical drainage. We shall have occasion to return to this point later.

This concept of the importance of bactericidal action in certain types of infection is borne out by many clinical observations; one of the best known examples is infection with the pneumococcus. The excellent results obtained in treating ordinary pneumococcal pneumonia with sulfonamides or with relatively small doses of penicillin are familiar to us all. The sulfonamides are bacteriostatic drugs and it is probable that in many instances concentrations of penicillin which achieve dramatic responses in this disease are sufficient to produce bacteriostasis only. In the lung, an ideal tissue for surface phagocytosis, the host defenses are at work. Further evidence of the importance of the host's resistance in pneumococcal infections of the lung is to be found in the prognostic significance of certain clinical findings in patients with this disease. Before specific antibacterial therapy was available and recovery depended entirely upon the host's defense, it was recognized that bacteremia, low peripheral leukocyte count, alcoholism, etc., indicated a lessened chance for survival in patients with pneumococcal pneumonia.<sup>4</sup> Although treatment with sulfonamides and with penicillin has, of course, reduced mortality in pneumonia, death, prolonged convalescence, or complications are still 5 to 10 times commoner in patients with these classic clinical findings indicating poor prognosis.<sup>5,6</sup>

When infection with this same organism, the pneumococcus, takes the form of empyema, endocarditis or meningitis, the sulfonamides are totally ineffective. Penicillin's effectiveness in empyema is dependent upon withdrawal of pus by thoracentesis and the repeated instillation of the antibiotic in high

concentration directly into the area of suppuration. If loculation, difficulty in aspirating particularly viscid pus, or other factors prevent the carrying out of this regimen, only surgical drainage will control the infection. Pneumococcal endocarditis was thought to be incurable until our present procedure for treating heart-valve infections with enormous amounts of penicillin over long periods of time was instituted. Pneumococcal meningitis, still a very serious infection, was curable only by repeated intrathecal injections of penicillin until it was found that the parenteral administration of fifty to one hundred times the dosage of penicillin needed in pneumonia produced comparable results. Even now intrathecal therapy is recommended by several authorities. Antibiotic antagonism, a much misunderstood and misinterpreted phenomenon, consists of the inhibition of the early killing effect of a bactericidal agent (i.e., penicillin, streptomycin, bacitracin) by a concomitantly administered bacteriostatic drug. In vitro and in experimental animals as well, it is demonstrable under special conditions of dosage and timing of administration only and it has not proved to be a clinical problem of any magnitude.<sup>7</sup> It is, however, of considerable interest that the only significant clinical demonstration of antagonism has been in pneumococcal meningitis where mortality was much lower in patients treated with penicillin alone than in a comparable group given a combination of penicillin and aureomycin.<sup>8</sup> No such difference in results was found in pneumococcal pneumonia. This is exactly what might be expected; bacteriostasis supplemented by the normal defense mechanisms is sufficient for recovery in pneumonia, but in meningitis where the antibiotic must bear the brunt of the battle because host defenses are sharply limited, even slight interference with penicillin's bactericidal action may be disastrous.

From these and similar observations we can arrive at the rule that bactericidal drugs are to be used whenever possible in infections of the serous cavities, including meningitis, in intravascular infections, including bacterial endocarditis, in localized suppurative disease (in conjunction with appropriate surgical measures), and in any clinical situation where it appears that the host's own defense mechanisms will not supplement mere bacteriostatic action of a drug. It is true that some forms of meningitis are cured with bacteriostatic drugs and that occasional instances of recovery from bacterial endocarditis have been reported to follow treatment with

bacteriostatic agents only, but these exceptions should be taken to indicate merely that the factors we have discussed are relative and not absolute as is so often the case in medicine.

#### THE ETIOLOGIC AGENT

A second important factor in choosing treatment is the infecting organism. The fact that we now have one or several antibiotics active against many species of bacteria has increased the importance of the clinical bacteriology laboratory rather than replaced it, but the overlapping spectra of the newer drugs and the great emphasis which has been placed on resistant strains, sensitivity tests, etc., have perhaps tended to make this aspect of the problem appear more complex than it is. It is neither practical nor necessary that the physician obtain detailed bacteriologic studies on every patient. On the other hand, in certain situations it is incumbent upon him to arrange for appropriate laboratory studies of the infecting organism.

The choice of an antibiotic in many infections presents no great problem. The meningococcus responds to sulfonamides and to penicillin. Penicillin is uniformly the preferable agent in gonococcal, pneumococcal and beta-hemolytic streptococcal infections. Resistant strains of these bacteria do not, for practical purpose, exist and if hypersensitivity contraindicates penicillin, aureomycin, tetracycline, etc., are also efficacious against these organisms.

In several infectious diseases the drug or combination of drugs which has given the best clinical results up to the present time is clearly definable. These include typhoid (chloramphenicol), the rickettsial diseases (aureomycin, chloramphenicol), brucellosis (aureomycin or terramycin plus streptomycin), syphilis (penicillin), tularemia (streptomycin, aureomycin), tuberculosis (streptomycin plus para-aminosalicylic acid or one of the analogues of nicotinic acid) and several others.

In still another group such as atypical pneumonia, psittacosis, "cat-scratch disease," and *Hemophilus influenzae* infections, several agents are apparently effective although the "antibiotic of choice" cannot be regarded as established beyond question.

There is next a group of diseases in which the use of antibiotics has given irregular or disappointing results although the infecting organism is clearly sensitive in the laboratory and there is justification for use of antimicrobial therapy in conjunction with other measures such as antiserum. These include

tetanus, other Clostridial infections, diphtheria, and leptospirosis in all of which penicillin is the preferable agent.

Lastly we come to the infections in which the complex of resistant strains, overlapping antibacterial spectra, and changing sensitivities combine to produce a situation which can be attacked only by the ingenuity of the physician backed by careful bacteriologic studies directed toward finding the most effective drug or combination of drugs. These include infections produced by the staphylococcus, the enterococcus and the Gram negative bacilli (including the colon bacillus, *Aerobacter aerogenes*, *Proteus vulgaris*, and *Pseudomonas aeruginosa*).

When penicillin was first introduced, most staphylococci were susceptible to its action. However, the progressive increase in the number of strains of this organism resistant to penicillin is now familiar to us all and has been reported in many parts of the world. At present from 60 to 80 per cent of staphylococci isolated from patients are resistant to penicillin.<sup>9</sup> There has also been an alarming increase in the number of strains of this organism resistant to aureomycin and terramycin as these drugs have been more widely used and it is fair to say that infections by the staphylococcus present a most serious clinical problem, a stimulus to the discovery of new agents as well as more efficient methods of combined therapy with those now available. It is difficult to generalize about the therapy of staphylococcal infections but certain statements can be made.

1. Careful bacteriologic studies and sensitivity tests are essential to proper management; there is no other basis for choosing treatment in this infection. Here clinical acumen or intuition must give way to the laboratory.
2. Because of the great ability of this organism to become drug resistant not only through the years, but in the course of a single infection, at least two drugs should be used. This is based on the well established fact that a combination of drugs is more likely to suppress the emergence of resistant variants.
3. Because of the tendency in staphylococcal sepsis to the development of infection in anatomic locations such as those already mentioned, as well as the increasing evidence that body defenses, including phagocytosis, are relatively ineffectual against this organism, at least one bactericidal agent should be included, if possible.
4. In no other infection is it more important to



institute surgical measures such as debridement and drainage when localized suppuration appears.

5. Once instituted, treatment must be vigorous and long continued because of a striking tendency to severe relapse in apparently cured cases. This is particularly important in view of recent suggestive evidence that exposure of staphylococci to suboptimal concentrations of antibiotics leads to the emergence of avirulent sports, the so-called "G-forms,"<sup>9</sup> which are often missed in culture and can revert to virulent types.

6. The close correlation that has been shown to exist between the introduction and use of each antibiotic and the increasing appearance of resistant staphylococci is a potent warning against the administration of antimicrobial drugs, no matter how harmless, in the absence of clinical indications.

It is my own practice in severe staphylococcal infections to begin treatment with large doses of aqueous penicillin (at least 12 million units daily) and erythromycin immediately after materials for bacteriologic study have been obtained. As soon as the results of sensitivity tests are known, the regimen can be revised. Erythromycin is active against many staphylococci but resistance to this drug can develop rapidly unless it is used in combination. If the organism proves to be highly resistant to penicillin, bacitracin in a dose of 20,000 units four times daily can be used for its bactericidal effect. Rarely, a combination of penicillin and streptomycin will prove to be effective in staphylococcal infections although synergism from this combination is more commonly observed in enterococcal disease. Aureomycin, terramycin, chloramphenicol and tetracycline are all useful in certain cases.

For infections due to Gram negative bacilli, there is a wide range of drug choice. In any serious infection due to the colon group, *Pseudomonas*, or *Proteus*, sensitivity tests form the basis for drug choice. Again, attention to ancillary measures, drainage, relief of obstruction (particularly in the urinary tract), etc., is essential. Polymyxin, a somewhat toxic agent, can be life saving in *Pseudomonas* infections. *Proteus* strains are extremely variable in susceptibility; the establishment of an effective regimen in these infections demands care and ingenuity. There have even been instances of *Proteus* infection in which cure was obtained after large doses of penicillin . . . no possibility should be neglected.

Lastly, enterococcal infections, particularly endocarditis, can be mentioned. Formerly almost hope-

less from the chemotherapeutic viewpoint because of great resistance of the organism to penicillin alone, enterococcal infections can now be treated with good results by a combination of penicillin and streptomycin. This is a striking example of synergism; an enterococcus resistant to large amounts of penicillin or to streptomycin alone is often killed rapidly by a mixture containing lower doses of each drug.

#### PECULARITIES OF THE AVAILABLE DRUGS

The commonly available antibiotics possess individual characteristics worth emphasizing.

Penicillin, due to its bactericidal action and virtual absence of direct toxicity for man, is well nigh the perfect antibiotic. The dosage which can be given is limited only by how much one can get into the patient. Jawetz mentions one patient who received 100 million units daily for a month, a total of nearly four pounds.<sup>10</sup> With high dosage, the use of an indwelling plastic venous catheter will avoid the discomfort of large intramuscular injections. One of the commonest errors in the interpretation of sensitivity tests is the abandonment of penicillin when an organism appears to be insensitive to the concentrations of penicillin routinely employed in these tests. One should always remember how good penicillin really is!

Resistance to streptomycin develops with great rapidity among common pyogenic bacteria such that within 4-7 days organisms may grow luxuriantly in hundreds of times the concentration of this drug that sufficed to inhibit a strain originally. This was one of the discouraging features of streptomycin in the treatment of urinary tract infections shortly after its introduction and resistance to streptomycin among tubercle bacilli was a great problem until the discovery that concomitant administration of para-aminosalicylic acid or now the newer niotinic acid derivatives will delay the appearance of insensitive variants in the course of therapy. Because of this tendency, the administration of streptomycin alone should be avoided, another drug being given at the same time wherever possible.

Bacitracin and polymyxin deserve brief mention. Parenteral administration of these agents can lead to serious toxicity. Nonetheless, both are highly useful to hold in reserve and, in proper dosage with supervision, they can be life saving in many desperate clinical situations. Their toxicity has been both over and under emphasized in the past but their

use is certainly justified in occasional cases of serious infection due to resistant bacteria.

In concluding this discussion of the factors to be considered in choosing an antibiotic, it is well to point out that this constitutes a serious problem in only a very small percentage of patients with infection. If one simply recalls the need for bactericidal agents in certain types of infection, does not attempt to substitute antibiotics for surgery, and obtains competent laboratory help in staphylococcal, enterococcal and Gram negative bacillary infections, many problems will solve themselves. Lastly, one should bear in mind the peculiar advantages of penicillin, the shortcomings of streptomycin alone, and the availability of such drugs as bacitracin and polymyxin for special cases.

#### THE CLINICAL RESPONSE

It is appropriate at this point to consider the clinical response which can be expected when the proper antibiotic is administered in correct dosage to a patient ill with an infection. It is obvious that if improvement is not apparent after an adequate trial, there should be immediate reconsideration of the original diagnosis, careful search for complications, complete re-evaluation of the case and appropriate revision of the therapeutic regimen.

There is a great tendency to regard the dramatic defervescence that commonly occurs in pneumococcal pneumonia treated with penicillin as the prototype of response of infection to antibiotics. This exceptional example of antibiotic control of severe infection is certainly not the yardstick. Although fall in temperature is an excellent indication of the efficacy of antimicrobial drugs, signs of improvement in many infections are evident before there is any reflection of recovery in the temperature curve. In most cases there should be symptomatic evidence of improvement within 48-72 hours after institution of specific chemotherapy but even in pneumococcal pneumonia this is not always striking and return of temperature to normal is not to be expected in many infections in this short period of time.

It is not possible to say that a certain pattern of response characterizes any single drug. With chloramphenicol, pneumococcal pneumonia responds in 24-48 hours, scrub typhus in 24 hours, typhoid in 3-5 days, and other *Salmonella* infections often after an even longer period. Again, the type of infection is important, an example being penicillin in pneumococcal pneumonia as opposed to pneumococcal empyema where illness is often prolonged for weeks.

Meningococcemia responds quickly to administration of sulfonamides but in meningococcal meningitis it is not uncommon for fever and disorientation to persist for 4-5 days after treatment is begun. In miliary tuberculosis, while subjective improvement is usually readily apparent as decrease in malaise, renewed appetite, etc., fever continues for a variable period. Because one should not institute antituberculous therapy unless the diagnosis is reasonably sure, it is only after a period of weeks that a change in regimen in this disease is justifiable on clinical grounds alone. Occasionally defervescence in miliary tuberculosis is surprisingly acute. Not only can fever persist for many days or weeks in bacterial endocarditis but new petechiae or serious embolic accidents are often noted after the institution of a course of antibiotic treatment which eventually brings about recovery. In this disease also, despite adequate control of the infection, heart failure or renal damage may progress to a fatal outcome.

It is as important today that the physician have some knowledge of the patterns of response to be expected after administering antibiotics as it is that he be able to recognize signs and symptoms in diagnosis. Only in this way can the therapeutic response be assessed and undue concern about the correctness of the diagnosis or possible undetected complications be avoided. Worse still, impatience and failure to appreciate the need for an adequate trial often leads to aimless shifting of drugs in a desperate attempt to hit upon an effective agent by the inefficient method of trial and error.

#### THE THERAPEUTIC TRIAL

Closely allied to the subject of the clinical response to antibiotics is the therapeutic trial. Of course the institution of antibiotic treatment in any patient is a therapeutic trial of sorts and the alert physician will not close his mind to the possibility of error in diagnosis or choice of drug until recovery is well underway.

It has been pointed out that even in large medical centers where the most modern laboratory facilities are available, the initiation of antibiotic treatment for acute infection is, in most instances, based upon a presumptive diagnosis.<sup>11</sup> This is derived from the results of careful history, physical examination and routine laboratory tests such as blood count, urinalysis, chest x-ray, etc., rather than isolation of the etiologic agent which may not be accomplished for 2 or 3 days. This presumptive diagnosis is sub-



ject to revision as more data are gathered and as the patient's course is observed. This concept is readily transferable from the wards of a teaching hospital to office practice or to illness in the home. Correct diagnosis is essential to correct therapy.

Although clinical findings alone are often insufficient for absolute assurance as to the nature of an acute febrile illness, an educated guess, a presumptive diagnosis, or at least a group of possible diagnoses should come to mind for consideration before any antibiotic is given.

In the case of upper respiratory infections, of which the overwhelming majority are viral in origin and will not be altered by any available antibiotic, it is all too easy to "cover the patient" with some antimicrobial drug without consideration of possible etiologies. However, in most instances the substitution of a moment's thought for a quick injection of penicillin will suffice to categorize the disease correctly if not specifically and symptomatic therapy can be prescribed with a clear conscience. If there is obvious pharyngitis, the possibility of streptococcal sore throat is sometimes impossible to rule out on clinical grounds and because penicillin will prevent the serious nonsuppurative complications of such an infection, the administration of this drug is more easily justified in this circumstance than in the usual acute coryza, tracheitis, or bronchitis.

The patient with an acute febrile illness without localizing signs pointing to predominant involvement of some organ system presents a difficult diagnostic problem. There are a number of brief, prostrating febrile syndromes of probable viral origin usually referred to as "grippe," etc., which can produce this picture. They are self limited and are not in the least modified by antibiotics. Given such a patient, the only possible excuse for institution of antibiotic therapy would be the possibility that the illness was bacterial or rickettsial in origin. Among the bacterial diseases to be considered are acute meningococcemia or other bacteremia without localizing signs (such as staphylococcal sepsis), acute miliary tuberculosis, brucellosis, typhoid, and tularemia. Obviously, not only would the random choice of an antibiotic fail completely to cover all of these possibilities, but the administration of the drug might well make isolation of the etiologic agent difficult, interfere with the procedures necessary for establishing the correct diagnosis, and delay the institution of proper antimicrobial therapy. In such a circumstance, careful observation for

spontaneous recovery, which is usually prompt if the infection is viral, or for the development of localizing signs and arrangements for appropriate diagnostic study if the clinical situation worsens, is the proper procedure rather than the indiscriminate exhibition of an antibiotic and hoping for the best. The unthinking institution of treatment with antimicrobial drugs in such a patient can also confuse the clinical picture; vomiting, diarrhea, or skin rash which might have diagnostic import if due to an underlying disease may simply be a result of drug toxicity or hypersensitivity. Lastly, malaise and fever without localizing signs are not pathognomonic of infection, lupus erythematosus, other "collagen diseases," lymphoma, hypernephroma, and blood dyscrasias being some of the disorders which can produce this clinical picture.

Without entering into an extensive discussion of F.U.O., fever of unknown origin, it seems appropriate to outline briefly the role of the therapeutic trial in this difficult diagnostic problem. It is not unusual to see a patient with fever and perhaps other clinical findings such as hepato-splenomegaly, anemia, etc., in whom the diagnostic possibilities have been exhausted. Hematologic tests, serologic tests, x-rays, multiple biopsies and cultures, etc., have been performed (often at several medical centers) without establishing the etiology of the illness. Either because of progressive debility or as a last resort in diagnosis, the decision is finally reached to treat the patient for a variety of diseases, to institute a therapeutic trial. Although the procedure to be followed will vary from patient to patient, two things are clear. First, in order to give the maximum information and ultimately maximum benefit to the patient, the agents to be tested must be given in adequate dosage for a proper length of time and this must be done in an orderly fashion. Second, because, as previously mentioned, all fevers are not infectious, the therapeutic trial should not be limited to antibiotics. The important possible diagnoses should be studied carefully and the specificity of the available agents as well as the speed with which a definite response, positive or negative, can be expected from them should be considered and a schedule arranged. As an example, in a patient with polyarthrititis a trial of aspirin for the possibility of rheumatic fever or of colchicine for gout should be carried out before penicillin is given to rule out the possibility of acute gonococcal arthritis. It may require as long as two weeks to obtain conclusive

evidence of success or failure with penicillin whereas the other two agents are easily tested within periods of 24-48 hours.

If fever and hepatomegaly are the prominent features of the illness, a trial of emetine is far more likely to give a clearcut result than treatment with aureomycin or streptomycin.

In patients with pulmonary infiltrates, chronic fever, etc., although a trial of streptomycin and PAS is justified, the prolonged interval needed to evaluate the result of this regimen for tuberculosis makes it proper to try other antibiotics first. In acute pneumonitis, apparently nonbacterial, raising possibilities such as atypical pneumonia, infectious mononucleosis, Q-fever, psittacosis, histoplasmosis, acute pneumoconiosis, etc., penicillin would be the preferable drug to begin a test. While several of the diseases might respond to aureomycin, only psittacosis is susceptible to penicillin. Among other drugs to be kept in mind are antimalarial drugs and nitrogen mustard. A response to these agents is usually prompt and their use will enable the physician to draw quicker and more definite conclusions as to etiology than will improvement after a prolonged course of antibiotics.

#### PROPHYLAXIS

It is entirely reasonable to suppose that if a drug is capable of curing an established infection, its early administration in circumstances of likely exposure to the causative organism might prevent disease entirely. This is indeed the case with sulfonamides and antibiotics but the experience to date with this type of procedure indicates that chemoprophylaxis is not only a complicated process involving many problems, but that it is as fertile a field for indiscriminate abuse as is therapy. There are, however, a number of situations in which benefits outweigh possible deleterious effects and in which the prophylactic use of antimicrobial drugs is indicated or acceptable.

In patients known to have had an attack of acute rheumatic fever, the administration of penicillin in small doses over a prolonged period clearly reduces the incidence of streptococcal infections and recurrences of acute rheumatism. Although sulfonamides are also effective, the occurrence of occasional strains of streptococci resistant to these agents makes them less preferable. Hypersensitivity is a problem, but a small one, and fortunately aureomycin is also available for alternate use in instances where peni-

cillin is contraindicated. Satisfactory results have been obtained using a variety of dosage schedules and routes of administration; the best regimen has yet to be determined. Although results to date justify optimism, it should be pointed out that the ultimate impact of this procedure upon the problem of rheumatic fever can be evaluated only after many more years of careful study.

Patients with valvular heart disease or with congenital malformations of the heart and great vessels can be partially protected from the possibility of bacterial endocarditis or endarteritis by the administration of antibiotics at the time of certain procedures. These include dental manipulations, tonsillectomy, genito-urinary surgery and normal parturition, all of which are known to predispose to transient bacteremia and implantation of infection intravascularly. Although penicillin is commonly used, it is probable that one of the newer agents active against Gram negative organisms is preferable for some procedures depending on the flora of the area involved. Here again there are problems to which we do not yet have the answer. It has recently been pointed out that the administration of large doses of penicillin for several days before such a procedure may so modify the normal flora that if bacteremia does occur and endocarditis results, the infecting organism is likely to be a penicillin resistant strain and hence a grave therapeutic problem.<sup>12</sup>

When epidemics of meningococcal infection, streptococcal sore throat, or bacillary dysentery impend in closed populations, prophylactic administration of sulfonamides (or penicillin in the case of streptococcal disease) has been effective in preventing spread of infection.

In certain unusual disorders predisposing to pulmonary infection, such as mucoviscidosis or agammaglobulinemia, continuous administration of antibiotics has apparently produced good results although the danger of infection by a resistant variant clouds the horizon here also.

The use of agents such as nonabsorbable sulfonamides, neomycin, etc., in preparation for bowel surgery is an accepted practice and in other surgical procedures involving danger of serious infection, prophylactic use of these agents postoperatively is probably justified; examples are craniotomy and thoracotomy. However, the routine administration of antimicrobial drugs after "clean" procedures such as herniorrhaphy is difficult to justify unless some break in asepsis has occurred.



It is common practice to administer antibiotics to comatose patients for the purpose of preventing pulmonary infection. Actually the problem here is one of aspiration pneumonitis or pulmonary infection in an atelectatic segment and no combination of antibiotics can be expected to substitute for proper removal of secretions from the tracheobronchial tree, positioning of the patient and good nursing care. If antibiotics are to be given as adjuvants to such a regimen, a combination of penicillin and streptomycin is preferable, because of the danger of infection with a resistant organism if any single agent is given. Lastly, in certain conditions such as severe burns, ischemic gangrene of an extremity or repeated bouts of pulmonary infarction in a debilitated individual, prophylactic use of a combination of drugs which will combat any expected pathogen with the least chance of risking secondary infection by resistant organisms is justifiable. In these situations a combination of penicillin and streptomycin is a reasonable choice.

In any contemplated prophylactic treatment with antibiotics, the risk of drug reaction should be weighed against the risk of infection and the drug should be selected with an eye to its effectiveness in combating the expected pathogen as well as the danger of superinfection by a resistant species.

This brief discussion of chemoprophylaxis can be concluded with another comment about viral upper respiratory infections, which have already been belabored. Probably the commonest excuse used in rationalizing the widespread practice of giving penicillin to patients with viral infections is the need to prevent secondary bacterial complications. It is first appropriate to point out that secondary bacterial infection is an uncommon sequel to viral infection. Secondly, even if prophylaxis is justifiable for the rare instances of secondary infection, a consideration of the etiologic agents responsible for these bacterial infections is the only rational basis for drug choice. Influenza bacillus infections in children are certainly not prevented by penicillin; indeed, overgrowth by *Hemophilus* is invited by administration of this drug. In viral influenza there is the definite possibility, statistically slight however, that staphylococcal pneumonia may complicate convalescence.<sup>13</sup> From our previous discussion of the present status of therapy of infections caused by this organism, it is evident that chemoprophylaxis would probably not only fail to prevent this disease but would almost assure infection with a resistant strain.

#### SOME OTHER METHODS IN THE MANAGEMENT OF INFECTIONS

Although specific antimicrobial treatment has received deserved emphasis in recent years, the importance of so-called "general supportive measures" is no less in infections than in other diseases. Antibiotics in no way replace attention to diet, fluid balance, bowel function, symptomatic relief and avoidance of complications such as thromboembolic disease or decubitus ulcers. There are also many techniques more directly related to the eradication of the infectious process which deserve brief mention.

#### SURGERY

Perhaps the commonest serious error in the treatment of infection at the present time is failure to utilize appropriate surgical measures when they are indicated. Blind reliance on antibiotics and disregard of the recognized limitations of drug therapy alone have led to neglect of basic principles. The importance of draining localized collections of pus has been mentioned. Relief of obstruction to drainage of secretions in many locations is of great importance, as is obvious if one recalls the peculiar relationship between obstruction and the establishment of infection. A partial catalogue of infections produced or aggravated by obstruction includes acne, furunculosis, dacryocystitis, paranasal sinusitis, otitis media, suppurative parotitis, mastitis, pneumonia and lung abscess, cholangitis, appendicitis, diverticulitis and a host of infections of the genito-urinary tract. In some of these, antibiotics may bring about temporary remission or occasionally a complete cure but all too often the removal of obstruction by surgical measures is resorted to only after prolonged and ineffective drug treatment.

There are many infections in which drug therapy can be regarded as purely supportive to surgical treatment. Appendicitis is surely a surgical disease. Chemotherapy in certain types of tuberculosis and in chronic lung suppurations such as abscess or bronchiectasis has made possible definitive cures by resection. In brain abscess, antibiotics can suppress infection and make practical neurosurgical procedures previously impossible to carry out without a grave risk of fatal cerebritis or meningitis. Lastly, it may be mentioned that in the case of bacterial infection of a patent ductus arteriosus, antibiotic treatment is secondary to the surgical interruption of the infected segment, a method which cures the infection promptly no matter what the sensitivity or resistance of the organism.

## ENZYMES

Through the use of the purified streptococcal products, streptokinase and streptodornase, the medical man is now able to encroach upon the territory of the surgeon by performing "chemical debridement" of superficial ulcerations, and thinning out viscid exudates so as to make aspiration through a medical needle replace drainage by a surgical scalpel in some types of closed infections such as empyema or arthritis. Use of these materials intrathecally has also been effective in combating subarachnoid block in meningitis. Another enzyme, trypsin, has been advocated for debridement and has also been administered by inhalation in attempts to liquefy thick secretions and to promote bronchial drainage in bronchiectasis and other suppurative pulmonary lesions.

## ADRENAL STEROIDS

Although there is a tremendous body of experimental evidence to indicate that ACTH and cortisone are deleterious to the host in infections of many types and this is supported by numerous clinical reports,<sup>14</sup> there is a strong possibility that these agents may find a place in the management of human infections. It has been established that the deleterious effect of cortisone in experimental infections which are ordinarily curable with antibiotics can be completely overcome by simply increasing the dosage of the antibiotic.<sup>15</sup> Because the treatment of human infections is ordinarily carried out with many times the "minimal curative dose" of a drug, concomitant specific antimicrobial therapy may entirely do away with the danger from these hormones in infections caused by drug-susceptible organisms. There is evidence that cortisone is a useful adjunct in the treatment of typhoid<sup>16</sup> and Rocky Mountain spotted fever<sup>17</sup> and preliminary results indicate striking benefit from these hormones in mumps orchitis.<sup>18</sup> It has recently been suggested, although little evidence is at hand, that the addition of these hormones to the regimen for bacterial endocarditis might permit better penetration of antibiotics into the infected valvular vegetations.<sup>19</sup> The efficacy of adrenal steroids in fulminating meningococcemia is suggested in the few reports of their use<sup>20</sup> but this is not yet definite. Although the administration of ACTH or cortisone cannot be recommended as routine practice in the management of any infection at the present time, there is enough evidence at hand to justify a careful exploration of their use at a clinical level.

## ANALGESICS

The common practice of giving aspirin or related drugs to febrile patients obliterates the usefulness of the temperature chart as an indicator of therapeutic response. It is my own practice to relieve discomfort with codeine or demerol when the situation permits, in order to preserve fever as a guide to therapy. However, if the decision to use aspirin is reached, it should be given in adequate doses at intervals of no longer than four hours. There may otherwise ensue a miserable cycle of sweating and chilling as the temperature swings up and down between doses and the patient's discomfort will be greater than before "symptomatic relief" was prescribed.

## MISCELLANEOUS CONSIDERATIONS

There remain a few points to be touched upon in this survey of the management of infections.

The local application of antibiotics to the skin and their use in the eyes and ears offer a wide area of usefulness for several potent drugs considered too toxic for routine parenteral use. Because of the enhanced opportunities for development of hypersensitivity to substances applied to the skin as creams or ointments, drugs such as penicillin are better reserved for the emergencies of life-threatening systemic infection. Fortunately bacitracin, neomycin, and polymyxin are highly effective in superficial infections such as external otitis or pyoderma; their toxic effects are no problem because absorption from the skin is negligible, and the development of hypersensitivity to these drugs is not very likely to interfere with future management of systemic disease since they are administered parenterally only in unusual circumstances.

A question which is often raised relates to the present status of sulfonamides in the treatment of infections. Sulfadiazine is an extremely good drug in meningococcal infections as are several members of this group; at present they are often combined with penicillin in treating this type of infection. In combination with chloramphenicol or some other "broad-spectrum" drug they are advocated by some in the treatment of *Hemophilus influenzae* infections in childhood although this regimen is by no means uniformly regarded as the best. Urinary tract infections sometimes respond to sulfonamides and they are very popular in this class of infections; an empirical trial of sulfonamides is often efficacious while definitive bacteriologic studies are being



carried out in pyelonephritis or cystitis. The usefulness of sulfadiazine in the prophylaxis of meningococcal and streptococcal infections and in dysentery outbreaks has already been referred to. There remains at present virtually no indication for the administration of sulfonamides in infections of the respiratory tract, even in streptococcal pharyngitis. In this disease their effect upon the clinical course is unimpressive and perhaps the most important deficiency of sulfonamides in septic sore throat is their inferiority to penicillin and aureomycin in the prevention of rheumatic fever. Although a great deal has been heard about combinations of two or more sulfonamides and they are widely advertised, there is little real evidence to indicate any advantage of mixtures over single compounds. A recent advertisement announcing that the production of sulfonamides now ranks second only to that of aspirin is incontrovertible evidence that the overwhelming majority of sulfonamides are prescribed without proper indication. Sulfonamides possess the advantages of low cost and ease of administration and they have rendered yeoman service in the past. There is little reason to believe that their popularity and production will not be maintained no matter how limited their usefulness in the treatment of infections may become in the future.

One year ago any discussion of chemotherapy would have devoted a large amount of attention to synergism and, particularly, antagonism between antibiotics. Synergism has fortunately occurred with a variety of drug combinations. On the other hand, it is good to be able to state that antagonism as a clinical problem has not materialized (with the exception of the studies on pneumococcal meningitis previously referred to) and it remains for the present a regularly demonstrable laboratory phenomenon. While combinations of antibiotics possess advantages in several situations, multiple drug therapy is not to be entered into without indications. Not the least of the problems arising from indiscriminate use of two or even three antibiotics concomitantly and in the absence of any real need other than an urge to "cover all possibilities" are the increased opportunity such a procedure offers for sensitization of the patient and the added risk of emergence of resistant strains of bacteria.

Lastly, "superinfection" deserves a word. Although secondary infections due to unusual organisms or bacteria resistant to the antibiotic being administered have been reported in isolated instances as complications of chemotherapy of infection, a

recently published study by Weinstein<sup>21</sup> indicates that this phenomenon is much commoner than has been realized. The incidence of superinfection (as manifested by clinical symptoms as well as cultural changes) was 2.2 per cent in a group of more than 3,000 patients treated with antibiotics. The occurrence of this complication was particularly common in young children, in respiratory infection, in viral diseases where an antibiotic was given "prophylactically" and after administration of "broad-spectrum" antibiotics. Contrary to the previously held idea that superinfection is more likely to complicate prolonged antibiotic treatment, the highest incidence was found to occur on the fourth and fifth days of therapy. These important findings simply add weight to the arguments against the therapeutic or prophylactic administration of antimicrobial drugs in the absence of specific clinical indications for their use.

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## RECONSTRUCTIVE MAXILLO-FACIAL SURGERY

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THE necessity for reconstructive surgery about the face certainly does not need to be stressed before a group of this sort. The human body is heir to injuries of all sorts and at all anatomical sites. People who have deformities of their upper and lower extremities are usually known as cripples. The term has not generally been applied to people with facial deformities but without a question of doubt the facial cripple is just as surely a cripple as people who have difficulties in ambulation due to damage to one or more extremities. Physiological problems, of course, always result from defects of the nose interfering with breathing, defects of the mouth interfering with eating, and, of course, those of the eyelids which interfere with sight. Regardless of what defect we are dealing with, however, any obvious deformity of the face can and very frequently does produce a psychological and emotionally crippling response in these unfortunate people. It behooves all men of medicine to consider these people as severe problems and to administer to their ills in the best fashion possible. Many of these deformities can be prevented by good medical care and many of them can be corrected by good surgery. It is the purpose of this paper to present some of these facial deformities and to discuss some of the means of their correction.

There are three main types of deformities that occur in the face; those that occur from tumor formations, those that are a result of congenital defects and those of traumatic origin.

### DEFORMITIES DUE TO MALIGNANT TUMORS

The first group, the tumors, can be subdivided into the malignant and benign and we will first discuss the malignant tumors, primarily the carcinoma. This is the most common type of malignant growth of the face. There are two main types, the basal cell and the squamous cell carcinoma. As you know, the basal cells are the least malignant but can be very deforming and can become squamous

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### SUMMARY

This paper is presented to demonstrate the three major groups of maxillo-facial conditions, namely, the treatment of tumors, treatment of congenital defects and treatment of traumatic maxillo-facial injuries.

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cell carcinoma. Squamous cell is more malignant, grows more rapidly, produces more damage, metastasizes early and is a tumor that must receive vigorous and early treatment.

The postauricular graft is a very effective graft for the eyelids and for the upper portion of the face. The upper portion of the face is also amenable to the receipt of grafts from the anterior supraclavicular area. These sites are chosen because the texture of the skin in the area above the upper lip is more like the postauricular and the supraclavicular skin than any other place in the body. This case represents the old story—the operation was a success but the patient died.

It is not unusual to have a patient come in with the whole side of the face involved and with a history of having had a lesion for 10 or 12 years and having never seen a physician. This type of case is seen mostly in large institutions with service cases of an economic level who do not seek medical care as much as they should.

In squamous cell carcinoma it is necessary to carry out a very radical form of treatment. Reconstruction of the nose can be effected in a number of fashions. One, it is possible to take a tube pedicle graft from the neck and bring it up to fill in the defect of the



nose and to reconstruct the nose. Secondly, it is possible to take the pedicle graft directly from the forehead and rapidly bring it down over the nasal defect. Thirdly, a sickle flap can be taken from the forehead and scalp which would very adequately replace the defect and reconstruct the nose. The nose can also be reconstructed from the abdomen and other skin of the body in the form of pedicle grafts but it is felt that if neck or face tissue is used the cosmetic results are better and quicker.

#### DEFORMITIES DUE TO BENIGN TUMORS

In dealing with benign tumors that occur around the face, one of the most common is a tumor of the mandible. Most benign tumors of the mandible do not require major resections of the jaws and consequently facial contour is not usually lost. The adamantinoma, however, can be a locally recurrent lesion and can eventually become an adamantinocarcinoma. There are many men who feel that an adamantinoma should be completely excised at the first operative procedure, including a hemisection of the mandible. Many men feel that local incision intraorally can be done and that if these recur they can be reoperated upon. The danger in this procedure, of course, is two fold. First of all the recurrence can be at the periphery of the previous lesion and can spread into inaccessible areas making a major restorative procedure a very difficult thing at a later time. Secondly, a constant return of an adamantinoma can become, as I said before, a carcinoma. There is a considerable difference of opinion in the treatment here. Many surgeons, however, doing local excisions report very good results over a period of years and they claim that for the few carcinomas that occur in these areas they have saved deforming procedures on many people. It is probably a fairly acceptable concept and I have limited myself to subtotal hemi-excisions of the mandible in cases where there is recurrence. In cases of adamantinoma when I possibly can I try very hard to save the condyle. If the condyle can be kept, the functional result is far superior. Even in carcinoma of the mandible, in the anterior part of the mandible, the tendency today is to save the condyle if possible for reconstructive procedures.

#### CONGENITAL DEFORMITIES

The next group of conditions which we will discuss are the congenital deformities. We will divide these into two groups, those which are physiologically disproportionate and that are likely to

produce functional defects and the so-called cosmetic groups. In the first group we include primarily cleft lip and cleft palate.

These deformities occur in approximately one out of 700 births in this country and as a matter of fact in most countries. There are various types of cleft lips and cleft palates. They can be unilateral or bilateral, incomplete or complete, involving just the lip or just the palate or both, or part of one or part of the other. Any conceivable combination that can be figured out has occurred and will continue to occur. Satisfactory results in the treatment of this condition are proportionate to the type of defect that exists. The wider the cleft, the more serious the defect, and the more difficult they are to cure. In recent days there has been a great tendency to develop teams for the rehabilitation for these unfortunate children and it is certainly a very valuable thing to have. The team should be divided into groups that are actively engaged in the physical and social rehabilitation of these children. In this group one has the plastic surgeon, the orthodontist, the prosthetic dentist, the general dentist who must keep the teeth in good condition, and not infrequently an ear, nose and throat man, and very frequently a pediatrician, and always a speech therapist. Also social workers, play therapists and occasionally a psychiatrist and a psychologist. We are going to concern ourselves here with only surgical correction of these deformities. We will first consider the deformity of the cleft lip. There are two types mainly to consider, the incomplete and complete, regardless of whether they are unilateral or bilateral. There have been countless hundreds of procedures to correct these deformities. The most outstanding of which have been the Blair-Brown modification of the old Mirault procedure and only more recently the Le Mesurier modification of the old Hagedorn procedure. The general idea is to get the lips together by a broken line technique. If a straight line closure is done, a vertical scar with severe notching forms. In the Blair-Brown technique a broken line procedure is used with a triangular flap utilized to build up the floor of the nose. In the Hagedorn procedure a quadrilateral shaped flap is utilized to break up the straight line. This last named procedure is exceedingly simple and effective and is the one most commonly used.

I believe it is unnecessary to explain the need for cosmetic surgery. There are a number of people who are emotionally disturbed by deformities and

we feel that surgery is definitely indicated, provided the surgeon feels he can improve the condition and providing he feels the patient is not psychopathic. Frequently it is necessary to get a consultation with a psychiatrist to evaluate the case prior to surgery. In many cases where there is an emotional disturbance much good can result from successful cosmetic surgery.

#### DEFORMITIES DUE TO TRAUMA

Under the heading of traumatic maxillo-facial injuries we can divide our field into a number of sub-topics. One, those involving the hard and soft structures, and two, those involving the soft tissue only. Under the first group we have the very severe traumatic injuries that we see as the result of automobile accidents, airplane injuries and things of that sort where there are lacerations, avulsions, fractures and dislocations of the facial bones. Under the second group we have the lacerations and avulsions and burns. In past years it had been the practice among many men doing this type of work to treat very severe maxillo-facial injuries by watchful waiting, bleeders were stopped, the patient was observed for a long period of time until the swelling went down at which time it was practically impossible to do any corrections. The result was a facial cripple. Today, however, with good anesthesia, antibiotics and blood it is advisable to do an immediate repair on these very serious maxillo-facial injuries if at all possible. If an immediate repair can be done on an injury of this sort, the outlook for the patient is remarkably improved. Less secondary corrective operations are necessary. A loss of one or two days, however, necessitates a correction to be done under tremendous swelling and possible infection. It is not possible to get good coaptation of tissue under these conditions nor to get good primary healing. As a result many reconstructive procedures are needed and a patient will be unduly placed under both economic and emotional stresses.

We are going to discuss here the most serious of all these types of injuries, namely, the full face fracture with lacerations and avulsions. The primary thing to consider in treatment of these cases is bleeding and shock. Before any soft tissue repair, however, is even attempted it is much wiser to repair the bony structures of the face primarily. It is extremely difficult to correct a bony fracture after a lip or nose or a cheek is sewed together. Then you have to go in behind the repaired laceration and treat the bone. A fundamental principle must be considered

in treating all injuries of these bony structures of the face and that is this, fractures must be reduced and fixed as in any other place in the body. These fractures are fixed by supporting them from the next most cephalad solid structure by wire. In the case of the fracture of the lower jaw the teeth are wired together against the upper jaw, and in case of a fracture of the upper jaw where the entire upper fragment is horizontally floating, in addition to wiring the teeth together, the jaw is suspended by direct bone wiring or cable wires to the malar bones or the infraorbital or lateral orbital ridges. Where the lateral orbital ridges or the malar bones are fractured an open operation is indicated and they are wired to the next most solid cephalad structure, namely, the supraorbital ridge of the skull. The fracture sites are exposed, frequently they are exposed by the injury itself, and small burr holes are made in the fractured bone and the next most solid structure above it. Small stainless steel wires are placed through the loop holes and the bones are wired into position. This is a very simple expedient and allows visualization of the fractures and excellent postoperative results. We are now discussing this direct bone wiring for the very serious types of fractures where simple procedures cannot be done. After the bone is fixed the soft tissues are repaired. Primary lacerations are closed with primary suturing. Loss of tissues producing large avulsive defects are corrected by the use of sliding rotation flaps from the neighborhood, or where this is not possible by the use of free skin grafts which are excised in multiple stages.

In the case of simple fractures of the facial bones such as the malar bone, there are a number of approaches to the malar bone fracture depending upon whether the anterior part of the body is involved or whether the zygomatic arch is involved. If the zygomatic arch is involved a simple approach is a Gillies operation where an incision is made above the hairline in the temporal area. A long slightly curved elevator is placed over temporal muscle and under temporal fascia downwards to the attachment of the temporal muscle and to the mandible, thus allowing the instrument to get under the zygomatic arch and using the skull as a fulcrum the arch is elevated. If the anterior part of the body of the malar bone is involved there are a number of approaches, the first of which is the Caldwell-Luc incisional approach in which an incision is made over the canine fossa. The anterior plate of the sinus is



usually fractured in this type of injury and an instrument is placed into the fracture site. All loose bone and debris are removed. The floor of the orbit is elevated by pressure and packed with gauze. This gauze is then passed out through the nose, through the middle meatus. If it is not possible to properly elevate the floor of the orbit in this fashion, a direct incision can be made in the infraorbital area through the skin down to the fracture site. The two fragments can be elevated, small burr holes drilled in each one and wired directly.

In injuries involving the soft tissue it is necessary, as previously mentioned, to correct the lacerations immediately and in the presence of large avulsions to correct the avulsion either by local rotation flaps or by the use of skin grafts which are gradually excised over a number of operative procedures. Sometimes a combination of rotation flaps and skin grafts are used.

Burns of the face of a third degree nature are extremely trying to treat. Usually full face burns involve loss of the nose or part of the nose, damage to the eyes or the eyelids and similar damage to the

ears, cheeks, and mouth. When these organs are destroyed the reconstruction is exceedingly difficult. I do not think any rules can be laid down for plastic surgical corrections of this type which I have discussed but I think a few things can be mentioned. Tissues must be handled atraumatically, fine suture materials and sharp needles must be used. In the first group, that of tumors, particularly the malignant tumors, the repair is not as important as the excision of the lesion, i.e., adequate excision followed by proper reconstruction. In congenital defects physiological function must be considered in the repair. In the cosmetic group it is obvious that the cosmetic result is the one that we are looking for and one must be very careful not to be over zealous and produce scarring that would be uncosmetic. In the traumatic maxillo-facial field the one most important thing that must be considered is immediate care with a maximum amount of work, if not all of it, being done at the first operative sitting. That is the most important axiom in this field.

Slides were shown with the presentation of this manuscript depicting various reconstructive procedures on the face.

## CERVICAL RUPTURED DISCS

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**A** BRIEF report is made on the surgical technique and results obtained in some 250 operative cases performed at the Hartford Hospital over the last eight years. All but six of these have been laterally placed ruptured discs, and such lateral cervical discs have occurred in a ratio of 1:7 as compared to lumbar discs. They constitute a distinct clinical entity and include most cases which previously had been diagnosed scalene syndrome. Approximately one-half give a chronic history of low grade discomfort in neck, arm, and radial fingers, but the other one-half run an acutely disabling course of severe disability and pain. Operation rather than

conservative waiting has been adopted in all cases unable to continue at work or to sleep throughout the night because of pain. The results have been amongst the most gratifying of any neurosurgical entity in the Hartford Hospital, with discharge from the hospital in one to five days and return to work in one to three weeks. Hence, from an economic point of view it is deemed a more conservative approach than prolonged rest and traction.

Operation is done in an upright position under local anesthesia with uncapping of the foramen and facet by use of a high speed dental type electric drill and extending the decompression into the lateral canal by use of a punch rongeur, resulting in a limited keyhole exposure. There have been no deaths nor serious sequelae, except for one transitory air

*From a discussion at the American Neurological Association, Atlantic City, 1954*

embolism, clearing without ill effects. Operation under local anesthesia with the patient conscious has minimized the likelihood of air emboli.

In contradistinction to lumbar discs there have been no late recurrences. No laterally placed disc has become converted to a centrally placed disc. Comment is made on the necessity of doing myelography in all cases, with myelographic diagnosis being made on a very slight root sleeve defect; plus a recognition that the bony changes of disc narrowing and foraminal encroachment frequently are

situated at one interspace away from the ruptured intervertebral disc.

Statistically, central cervical ruptured discs have been rare on our service and constitute an entirely different clinical entity with severe disability of paraplegia or paraparesis. Operation has been unsatisfactory because of probable cord ischemic changes in all but the fresh, acute cases. These require a laminectomy with a combined intra- and extradural approach with extreme care taken to preserve the spinal cord from damage.

## PARTIAL SECTION OF PROXIMAL SEVENTH NERVE FOR FACIAL SPASM

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**F**ACIAL tic occurs in middle and older age groups, frequently with hypertension, and constitutes a most fatiguing and embarrassing disability. Previous surgical procedures and alcohol blocks have proved unsatisfactory because of initial total paralysis followed by progressive return of spasm. German developed a more satisfactory method of partial sectioning of the terminal branches of the facial nerve distal to the parotid gland.

Presentation is made of partial sectioning of the main trunk of the facial nerve distal to the stylo-mastoid foramen and just proximal to its first branching. This location offers certain technical advantages in the exposure and sectioning of the

nerve at the point of its greatest diameter; with less likelihood of regeneration; and a largely invisible scar.

Six cases have undergone operation and been followed for  $1\frac{1}{4}$  to 6 years. The results have been gratifying. Partial sectioning of approximately three-quarters of the diameter of the nerve, with ligation and rolling backwards of the cut portion, sufficient to cause temporary weakness is carried out under local anesthesia. Cessation of the tic is immediate and there is a return of normal facial function in approximately three months' time. Over the ensuing one to three years, there has been only a minimal return of twitching, chiefly of the lower eyelid, sufficient to warrant reoperation in only one case. This early case had had an inadequate section. There have been no untoward reactions.



## THE VALUES OF LATER MATURITY: NEED FOR RE-EDUCATION

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**M**Y objective in this discussion is to suggest that educational effort shall be used to devise improved criteria for the values of maturity and shall utilize modern methods and materials for the purpose of evoking the potentialities of life in later maturity.

The IQ and its criteria continue to grow in their service to education in war and in peacetime activities. Some advance may even be expected in the revision of its criteria as applied to older people. Recognition is also emerging with respect to an EQ, the emotional quotient. Criteria are being generally indicated for it in terms of stability, poise and qualities which contribute to full-rounded mental health.

Currently, Dr. Edward L. Bortz of Philadelphia says, "There is now need for an MQ, a maturity quotient."<sup>1</sup> Here criteria are not specifically defined and this being the case, the situation is a challenge to aging and it is a challenge to education.

The peak of the maturity curve is reached latest in life. Physical maturity comes at about age twenty-five. Emotional maturity, in the days when I had occasion to evaluate it, seemed to be reached well after age thirty. But that date must have been pushed well forward with youth at war and engaged in administrative responsibilities throughout the world.

The maturity curve reaches its highest commercial value on or about 45 years of age in many types of gainful employment. But it must be noted that government, industry and finance reward men most richly with the heaviest administrative loads frequently in their sixties. This, I submit, is a social phenomenon which carries weight as a criterion. If such values are ready and available there, why are we not actively engaged in cultivating them during the second half century of life? Is it because aging people are not asking to be explored and experimented with? It may also be because opportunity is not freely offered to them.

The other day my witty and talented sister-in-law in California enclosed in her letter a copy of a quaint little poem which some of you may remember. It seems apposite to this discussion:

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The Author. *Member, Executive Committee,  
Connecticut Society of Gerontology*

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### SUMMARY

Not only is there an IQ (intelligence quotient) and an EQ (emotional quotient) but also an MQ (maturity quotient) to be applied to older people. The potentialities of the individual in his sixties or over are listed and three of them in particular are discussed as they apply to education in later maturity: viz., psychological progress, spiritual unfoldment, and mental development. It is anticipated that the average span of life will be definitely increased during the next fifty years, hence there arises the need to make the later years of life more useful.

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"King David and King Solomon  
Led merry, merry lives  
With many, many lady friends  
And many, many wives.

"But when old age crept over them  
With many, many qualms,  
King Solomon wrote the Proverbs  
And King David wrote the Psalms."

Now, on the eve of his 69th birth date, this King David would like to submit to you one brief Psalm. It is this:

At every age, however advanced or circumscribed,  
every individual has at command potentialities  
which may be realized when there is incentive to  
strive for them.

There is no startling revelation here. Everyone, I am sure, will endorse the statement. The real question is, how may we implement the discovery and utilization of these potentialities?

From my point of view, the potentialities reach farthest into the later years of maturity under the following categories:

1. Psychological progress.
2. Spiritual unfoldment.
3. Mental development.
4. Special physical skills.

5. Social interests, especially in group organization and group accomplishment at many significant levels.

I am sure education can come to grips with the problem on every one of these levels. Moreover, education has made a good start with respect to numbers of them. We shall briefly discuss three of these categories. I believe they have not been given fully adequate curriculum consideration in so far as they apply specifically to education in later maturity.

#### PSYCHOLOGICAL PROGRESS

A prerequisite here is that it must be admitted that capacity for change and growth are inherent in life when it reaches maturity. Capacity for change and growth is an aspect of a process which follows upon insight and understanding of the nature and resources of life. It is with respect to the resources of life that psychology can contribute liberating influence. Age is no bar to such learning. A watered down psychological dosage about feelings and attitudes is well enough in its place. But let us not neglect the few hardy older persons who will be willing to devote themselves to study and research. They await opportunity and education's invitation. My vote is for the Jungian approach. The *Psychology of C. G. Jung*, by Dr. Jolandi Jacobi of the Jung Institute, Zurich<sup>2</sup> might be used as a beginning text. For such a group there can be great significance in the victory of comprehending values of an unconscious totality which encompasses all human experience. Also, as a totality which faces all future potentials both human and divine, the unconscious becomes resource to which consciousness can give untiring attention with an entirely new joy of understanding and humility. That victory for a group would have wider significance than mere group achievement. Probably Dr. Jung himself, now in his 78th year, would be keenly interested to learn of such an experiment.

#### SPIRITUAL UNFOLDMENT

There may not yet be many to whom this is open. This is not because the potentials are denied to the many. Rather it is because there are too few who dare. But for those with the courage there can be unique significance in the transition from dogma to experience, from form to life. Abraham bargained with God that ten men might save the city. Now that virtue abounds within the modern city walls, no more than five should be needed, I believe. For

that many to devote themselves to research in spiritual unfoldment, one might hope turning to interdenominational collaboration could achieve it. It would be a discussion group. For texts it could use Huxley's *Perennial Philosophy*, Norman Cousins' *Who Speak for Man*, and Paul Tillich's *The Courage To Be*. No one may chart the course of a group of older people undertaking such a study. It is enough to say that with such material it would consider the philosophical and spiritual riches of all known literatures; it would survey the work of human thought with its brotherly yearning just as it is; it would face the systematic knowledge of being as it may ultimately be contemplated.

#### MENTAL DEVELOPMENT

The curve of mental decline in the normal aging process is a gentle one. Anybody with modest intelligence and moral stamina can lift it up, can in most cases reverse its declination. In this area current utilitarian educational objectives will probably predominate. A content directed to meet the needs of the aging and that will develop services for them will be essential for some time to come. Even so, we will be restricted to selected personnel with whom to work and serve. It is this speaker's hope, however, that the restriction may not be as drastic as is commonly thought. Obvious deterrants are life's increasing distractions and the lag in continuing education through the middle and the later years. It must be admitted that formidable determination will characterize those elders who will take time out from auto, cinema, radio and television to undertake studies which will benefit older people in the community. But when right opportunity under adequate auspices is offered, we may well be satisfied to find a few to undertake the disciplines. If they do, even a group of twenty or so could progress as a revolutionary force in a municipality of 150,000 and its environment. Examples which point the direction are encouraging:

1. There is the flourishing Cold-Spring-on-Hudson Project of the Walt Foundation. To this one may repair with blankets, sheets, pillow cases, towels and bath mat—plus college tuition and residence fee of \$2,250—for a full twelve month's course. In relatively luxurious environment one may there learn how to resolve his own personal aging problems, intellectual, psychological and physical, and how to undertake leadership in planning competently for industrial and community programs for older people back home.



2. There is the Grand Rapids extension course put on by the Gerontological Division of the Department of Human Adjustment, University of Michigan, directed by Wilma Donahue. In 1949 Dr. Donahue inaugurated a workshop course with a modest group of older people under the auspices of a committee of citizens having responsible relationship to the industrial and administrative affairs of the city. The first semester saw the beginning of two significant community services developed by the practical genius of the class. A series of courses followed, culminating last year in the publication of *Older People Tell Their Story*.<sup>3</sup> This is an account by Woodrow W. Hunter and Helen Maurice of the introductory studies of the class, how the community was stimulated to join with the older students in the preparation of a questionnaire, the training of volunteers, and the census of the city's older population. A significant value of the census is that it presents what the senior citizens have to say about their health, work retirement, financial security, living quarters, social relationships, leisure time activity, religion and attitudes toward the community. In conclusion, a one day community forum was conducted and recommendations for the development of programs and services were devised by the forum sections. It seems probable that the senior training group of Grand Rapids will remain a dynamic focus for future programming in behalf of social welfare and self accomplishment among the city's older citizens.

3. Beginning in 1951, the University of Chicago through its Committee on Human Development and the University College, under the direction of Dr. Robert J. Havighurst, has conducted a series of full semester courses confined to the needs, interests and welfare of the older students who have enrolled for them.

4. There are courses for retired farmers in prospect of formulation by the University of Iowa.

5. There is the attempt of the Public School system of Los Angeles to give mass educational services in variety to older citizens of that sprawling city. At the 16 schools assigned for such service, 19,076 senior citizens enrolled in the winter sessions of 1950-1951, and courses in gerontology followed at UCLA to train instructors and group leaders in sustaining the expanding program.

Altogether, there is a rich ground of experience upon which to build new educational programs for older people. I believe we should search for methods which can be used to train older citizens of execu-

tive caliber to develop "teams with special skills in working with and in communities so that the usefulness of older people will be enhanced and provisions for their continued activity may be strengthened." In this field I think the workshop technique can be used to advantage for proficient development of teamwork in services to our aging population.

There is no need here to discuss potentialities in the categories of special skills and social services. Texts, studies, and professional training abound in this area. Rather, it is my intent to direct consideration to the possibility of developing social mechanisms which can serve latent capacities of older people at, as yet, more restricted levels of experience among the aging. The performance of such work is worthy of the best educational talent that society can contribute.

It is a new field and it widens before our eyes. Dr. Bortz warns us that the potentialities of longevity are but at a beginning stage. He says there is a possible correlation between skeletal maturity and the normal length of life. Among domestic animals the fusion of the shaft and small bone of the long bones of the body furnish a possible clue. These bones fuse in 1½ years among cats whose lives average 9 years; for dogs the fusion occurs in 2 years and their lives average 12 years. In the case of horses the fusion age is 3 and the average life is 18. For you and me this fusion occurs at about age 25 . . . however, it may be questioned whether we shall live to be 150 under present conditions of living. Nevertheless, this is only one warning among many that the average span of life will be substantially extended during the rest of this century. Education, I believe, should expand its programs to assist in making longer life worth living.

The need to make life useful throughout its later period is a need of increasing significance. The responsibility for doing so rests first upon the aging themselves and second upon the facilities which education can furnish. There is a warning and a challenge in Leonard Bacon's poetic phrasing:

"Have you learned Autumn yet? For I have not.  
It is a harder language than Spring or Summer,  
Richer in connotations, with more color,  
More resonance, and more finality  
In its more positive phrasing. I am resolved  
At length to master it."

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## CONGENITAL LEUKEMIA

C. E. MCLEOD, M.D., and C. B. CRAMPTON, M.D., *Middletown*

## INTRODUCTION

Buffin & Davis<sup>1</sup> recently stated that leukemia is the third most frequent neoplastic condition among children admitted to Duke. Congenital leukemia, however, is infrequently reported but it is possible that the condition is not as rare as a survey of the medical literature indicates since cases of leukemia in newborns can be mistaken for erythroblastosis, congenital syphilis, or may be recorded carelessly as "multiple congenital defects" unless postmortem examinations of the babies are made. The purpose of this report is to record a case of acute myeloblastic leukemia occurring in an infant who lived only 1½ hours, to summarize the previously reported cases, and to emphasize the value of postmortem examinations on stillborn and neonatal deaths.

## CASE REPORT

The mother was a 19 year white girl in her first pregnancy, EDC May 8, 1954, Bl Gr O, Rh positive, VDRL negative. Complete blood count four days after delivery was entirely normal. The past history was devoid of any serious illness or operation. The family history was negative except for an uncle who has diabetes. The course of pregnancy was quite uneventful. Labor began at term, progressed normally and an easy Scanzoni maneuver served to deliver the baby who was small (5 lbs. 3 ozs.) but appeared vigorous. Aside from fusion of two toes nothing unusual was noted immediately upon delivery and the baby, because of its small size, was placed in an Armstrong bed while the third stage of labor was completed. Upon further examination of the baby a little later, enlargement of the liver and spleen were noted and there was cyanosis with increasingly difficult respiration. The infant expired in about 1½ hours.

## PATHOLOGY REPORT

Permission for postmortem examination was obtained some 13 hours after death and the following positive findings noted. Heart blood was aspirated and a blood count performed on it showed hemoglobin 7.9 gms./100 cc. blood, erythrocytes 2.4 M per cm., leukocytes 40,000 per cm. A study of a smear revealed 2 per cent polymorphonuclear leukocytes, 1 per cent non segmented polymorphonuclear leukocytes, 22 per cent nucleated erythrocytes and 75 per cent blasts. The erythrocytes showed moderate polychromatophilia, moderate anisocytosis, slight poikilocytosis and macrocytosis. The blood was Group O, Rh positive, the same type as that of the mother. The skin was slightly icteric and the tissues pale. The only congenital anomaly

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## SUMMARY

A case of congenital myeloblastic leukemia is described together with a discussion of previously reported cases. The association of this disease with congenital anomalies is emphasized. Postmortem examination of stillborns and infants dying in the neonatal period is a valuable contribution to the classification and knowledge of disease.

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externally noted was webbing of the right 4th and 5th toes. The peritoneal cavity contained a minimal amount of thin amber fluid. The liver extended 10 cm. below the costal margin and weighed 250 Gm. There was slight prominence of the mesenteric nodes. The spleen weighed 10 Gm.

## MICROSCOPIC EXAMINATION

The bone marrow was crowded with uniform, poorly differentiated cells of the granulocytic series, megakaryocytes were scarce and erythropoiesis was greatly reduced. There was also leukemic infiltration of the lungs, heart muscle, kidneys, adrenals, lymph nodes and spleen. There was such extensive leukemic infiltration of the liver that the sections were hardly recognizable.

## REVIEW OF LITERATURE

Kelsey and Anderson<sup>2</sup> in 1939 reviewed the literature on leukemia occurring in the neonatal period. They were of the opinion that the following criteria should be present before one calls an early developing leukemia a "congenital leukemia." Clinically the symptoms should present themselves either at birth or within a few days after birth. There should be hepatomegaly, splenomegaly and enlarged lymph nodes. The peripheral blood should show leukocytosis with the presence of immature cells. The history should be free of any indication of syphilis, icterus gravis neonatorum or erythroblastosis. Histologically there should be more cellular infiltration than could plausibly have occurred in the extra-



uterine life. There should be an increase in the number of immature cells rather than a mere increase in the hemopoietic centers. Cellular infiltration should involve nonhemopoietic organs as well as the liver, spleen and lymph nodes.

They found only 9 cases in reviewing the literature which fulfilled these criteria and added a case report of their own. Cross<sup>3</sup> reported the 10 cases included in Kelsey and Anderson's review,<sup>2</sup> collected eight more from the literature and added two case reports. Bernhard, Gore and Kilby<sup>4</sup> listed 14 cases from the literature including 13 reported in the above two papers and one additional case from the literature and added four cases from the files of the Armed Forces Institute of Pathology. Further search of the literature reveals six additional cases<sup>5,6,7,8,9,10</sup> that were not included in any of the above reports. Thus the total number of cases is 31.

#### COMMENT

Our case was definitely one of congenital leukemia in that it survived only 1½ hours and fulfilled the other criteria for diagnosis as set down by Kelsey and Anderson,<sup>2</sup> namely, hepatomegaly, slight splenomegaly, lymphadenopathy; and the peripheral blood showed evidence of leukocytosis with the presence of immature cells. Histologically there was an excess number of immature cells in the hematopoietic organs plus cellular infiltration in the nonhematopoietic organs. The history was free of any indication of syphilis, icterus gravis neonatorum or erythroblastosis. There was no evidence of leukemia in the mother and no family history of leukemia.

Bernhard<sup>4</sup> et al pointed out the developmental anomalies associated with congenital leukemia in three of their four cases and in one additional case in the literature.<sup>3</sup> They also noted that because of the cursory reports of postmortem examinations in eleven instances in the literature a malformation might have gone unrecorded. Schunk and Lehman<sup>10</sup>

have since reported another case of mongolism and congenital leukemia. The anomalies which have occurred have been those which entailed damage between the 5th and 14th week of embryonic development. Ingalls<sup>11</sup> is quoted as suggesting that occasionally during this period of development the bone marrow sustains an injury which culminates in leukemia. The malnutrition of the hematopoietic system begins in the seventh week.<sup>12,13</sup> Our case had one congenital anomaly, namely, webbing of the right 4th and 5th toes. Keith<sup>12</sup> states that the digits become free at the end of the 8th week, which would place the damage at the same period as that of the others reported.

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ACTINOMYCOSIS

ACTINOMYCOSIS is fortunately a rather rare infection, resistant to treatment, and yet uncommon enough to deserve some notice when encountered. In recent years there has been improvement in the therapy and prognosis due to the use of many of the antibiotics but there still remains a rather important basic surgical aspect of the infection which calls for emphasis, namely, adequate surgical drainage.

The following case report brings out this point.

A. M. C., 5 year old white girl, was treated for two weeks by her family physician for a low grade, purulent infection of the right cervical region with penicillin and soaks. The "abscess" formed in the lower cervical region, posterior to the lower third of the sternocleidomastoid muscle and spontaneously drained after 96 hours. It continued to drain but did not appear to be clearing up and after two weeks the anterior chest wall between the level of the clavicle and the nipple became swollen, hard and red. There was little general reaction in the patient and, despite the phlegmonous character of the anterior chest wall, it was not particularly tender to palpation. It was at this time that the author first saw the patient. She was permitted to stay home for Thanksgiving Day, inasmuch as there was no satisfactory point of localization and it was felt that continued antibiotics and wet soaks could be as well applied at home. On the day after Thanksgiving, 1952, the status of the lesion was essentially unchanged and the patient was admitted to St. Francis Hospital, Hartford, Connecticut for further care. This consisted of further soaking, x-ray therapy, and terramycin but it still failed to present a fluctuant point and after seven days incision was decided upon. This decision was made for two reasons. The failure to localize suggested something unusual in the type of infection which warranted culture, and x-ray studies revealed some haziness in the upper right lung field suggestive of pleural reaction and there was some periosteal thickening of the ribs which indicated that the inflammatory reaction was infiltrating the deeper tissues. The patient showed some generalized reaction with a temperature up to 101 and an elevation in the white count. The BSR was 100.

Incision into the chest lesion was made over the center which was about 2 cm. from the midline, overlying the right third rib. The tissue was edematous and in deeper it was necrotic. This material was examined at once microscopically and found to contain actinomyces. The inflamed area was carefully exposed and, while the edema and slough were found in the fat and superficial fascia, there was no sign that the pectoral muscle and fascia had been perforated by a sinus tract. There was established a con-

A Case Report

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SUMMARY

A case of actinomycosis of the cervicothoracic type is presented and a plea made for the combined use of adequate antibiotic therapy and adequate surgical drainage. The cure in this patient is attributed to this regimen.

nection between the cervical component and the thoracic area but this was a relatively narrow line and tissues adjacent to it were as normal as any area outside the perimeter of reaction on the chest wall. After a second search of the floor of the cavity in the chest wall to exclude a hidden sinus, the wound was packed open.

The patient was then given a heavy course of aureomycin, 750 mg./day followed by Biosulfa, ½ Gm. b.i.d., along with the necessary changes of dressing consistent with keeping a surgically clean wound. Over the next forty days the chest wound gradually closed. The cervical wound closed about ten days after incision and drainage of the chest wound and remained closed. Gradually the hard, edematous character of the tissues receded and, as the healing progressed, the tissues assumed a normal degree of softness. The reaction of the ribs subsided and the BSR gradually fell to 14, two weeks after operation. When the wound had been reduced to a small superficial affair and the BSR had steadied at 4 mm., the patient was treated on an outpatient basis and was kept on aureomycin for 8 weeks. She continued to gain in weight and appearance and the infection never reappeared. She was seen every month for six months and then has been seen at six month intervals since that time. There has been no trace of reinfection in this patient.

A case of actinomycosis of the cervicothoracic type is presented. It has been followed for twenty months and no recurrence has been observed. The literature on this infection and its treatment has been relatively scant and all the antibiotics have been tried. Improvement has been noted with all of them. It is my opinion that great help was received from the antibiotics in this case but the definitive step was incision and turning the course of the infectious invasion to the surface, rather than permitting it to



smoulder and burrow deeper into the chest wall which was its obvious course when the patient was first seen. While the antibiotics definitely assisted in preventing further infiltration in the postoperative phase, I believe that the emphasis in bringing about a cure must be directed to the basic concept of incision, drainage and good surgical cleanliness in the treatment of surgical infections.

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## CAROTID SINUS SYNDROME

### THE CAROTID SINUS

The carotid sinus is the bulbar expansion of the common carotid artery at its bifurcation in the neck.<sup>1</sup> Among the collagenous fibres in the wall of this portion of the carotid are situated sensory end organs or proprioceptors which respond to mechanical stimulation, hence are given the name of pressoreceptors. Normally this stimulation is brought about by a stretching force such as the increase in intravascular pressure. Another group of sensory organs are found in the carotid body nearby and respond to chemical stimuli, notably anoxemia. The pressoreceptors play an important role chiefly in the regulation of circulation, while the chemoreceptors are accessory factors in the control of the respiratory function. The arc of the sinus reflex is made up of afferent fibres contained in the sinus nerve, a branch of the glossopharyngeal. Efferent connections are made with the medulla through fibres of the vagus and with the sympathetic chain

### Report of Case With Fatal Outcome

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#### SUMMARY

A case of carotic sinus syndrome is described in which attacks showed increase in rate of recurrence as well as intensity eventuating in convulsive seizures. Medical measures gave only temporary relief and surgery was refused by the patient. On autopsy, findings of vascular sclerosis were made but no significant cardiovascular pathology or evidence of compression in the neck that would have been responsible for the syncopal disorder were found.

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through filaments to the superior cervical ganglia. It was thought at one time that the depressor reflex of the carotid sinus was due to pressure on the vagus nerve. This has been disproved by the demonstration that the effects are seen when pains are taken to

avoid vagal stimulation, as by electrical stimulation of the sinus wall or traction on the cephalic end of the sectioned carotid without making contact with the vagus nerve. Likewise, in the course of operations in the neck, pinching of the vagus with forceps fails to cause stimulation. Hence, it is the nerve plexus in the carotid sinus that is responsible for the depressor reaction and section of the sinus nerve or stripping of the carotid sinus obliterates the effects on the circulatory system.

#### HYPERSENSITIVE CAROTID SINUS

The monumental work of Weiss and Baker in 1933 demonstrated that hypersensitivity of the carotid sinus was not an uncommon clinical finding. They showed that in patients with hypertension and arteriosclerosis, pressure on the carotid sinus resulted to a varying degree in a prompt fall in blood pressure and/or pulse rate in from 70-78 per cent of cases observed by them. They further described a third type which they called the cerebral form in which the manifestations of cerebral anemia—syncope and convulsions—unaccompanied by primary changes in pulse and blood pressure could be reproduced by this maneuver.

#### CAROTID SINUS SYNDROME

This syndrome—called vasovagal syncope by Lewis—consists of paroxysms of dizziness and fainting resulting from overactivity of the carotid sinus reflex, and are usually associated with bradycardia and hypotension. These occur in absence of overt stimulation. They have occurred in presence of emotional disturbances, or from buttoning of a tight collar or sudden turning of the head. In these subjects, hypersensitivity of the carotid sinus is demonstrated in the interval between spontaneous attacks by reproducing similar episodes with mild pressure over one or the other of the carotid sinuses. It must be pointed out that the induction of these paroxysms is not without danger. Brannan<sup>2</sup> in 1948 described hemiplegia following in the wake of such a test and this has since been substantiated by others.

#### CASE REPORT

This was the third hospital admission of a 72 year old, white male with chief complaint of repeated fainting spells.

First admission—May 26, 1953. Patient denied presence of any chronic illness in his family and any serious illness in his own past history. He was a painter by trade and had been entirely well up to several weeks prior to entry. At that time, while watching television he fainted. He roused himself after an unknown period of time, feeling entirely normal. Two days prior to admission he again fainted while shaving.

The review of systems was essentially negative except for complaint of dysuria. Positive physical findings at this time: A well developed, well nourished, elderly white male lying comfortably in bed. Eyes: pupils round and equal, react promptly to light and accommodation, external ocular muscles: normal. Fundus: Grade II retinitis. Mouth: clear, tongue protrudes in midline. Neck: supple, no adenopathy; thyroid, not palpable. Trachea in midline. Chest: good and equal expansion. Lungs: resonant and clear. Heart: Good quality, normal rhythm, no murmurs. Abdomen: obese, soft, non tender. No visceral enlargement. Reflexes: physiological. Prostate: enlarged with few stony-hard nodules.

Laboratory data: R.B.C. 4.67—Hgb. 14.2 Gms. (88 per cent); W.B.C. 8,900; Sed. rate: 11mm/hr.; B.U.N. 18 mg per cent; Creatinine 1.0 mg per cent; Cholesterol 156. mg per cent; VDRL—negative; Urine—sp. gr. 1.020, sugar-negative, albumin-faint trace.

X-ray: Chest: Slightly increased pulmonic markings. No evidence of infiltration. Thickened pleura in left costophrenic angle. Cardiac shadow within normal limits. Aorta shows evidence of arteriosclerosis. Skull including sella turcica, normal.

Because of his long standing complaint of dysuria it was decided to proceed with this part of his treatment, he therefore had a suprapubic prostatectomy performed with uneventful convalescence. There were no spontaneous attacks of syncope.

Impression: Syncope of undetermined origin. Arteriosclerosis of aorta and probably cerebral arteries. Prostatic cancer.

Second admission: July 2, 1953. Three weeks following discharge, he was readmitted by ambulance as a result of loss of consciousness. He was found in this condition by his wife at about 4 A. M. Later he reported that he had had few attacks of fainting since he left hospital. Physical findings at this time unchanged. Blood pressure: standing: 128/80, sitting: 130/76, recumbent: 128/68.

Glucose tolerance test: Fasting specimen: 96 mg. per cent; ½ hour 188 mg. per cent; 1 hour 146 mg per cent; 2 hours 90 mg. per cent; 3 hours 82 mg. per cent; 4 hours 105 mg. per cent; 5 hours 107 mg. per cent.

G.B. Series: Normally functioning gall bladder containing no stones.

E.K.G. Occasional premature ventricular beat from single focus in left ventricle. Second E.K.G. Normal record, P.V.B. gone. After-exercise test: Normal record.

Pressure on left carotid sinus precipitated fainting attacks associated with abrupt drop in blood pressure to zero and disappearance of pulse at wrist. On revival patient volunteered that he had just had another fainting spell of the type that he had previously mentioned. Consultation with Dr. J. C. Mc Nerney, a neurosurgeon, was requested with a view toward definitive treatment. He reported that except for bilateral anosmia, cranial nerves, cerebral motor and sensory systems seemed within physiological limits. Compression of left carotid sinus precipitated syncope. No evidence of intracranial space-taking lesion was found. Petital was considered but patient's age made this unlikely and an E.E.G. done the following week was reported normal. During this hospital stay patient had frequent spells of



fainting on moving head to left. Procaine infiltration was suggested but refused by patient.

Impression: Carotid sinus syndrome.

Patient, therefore, was sent home on phenobarbital and atropine. He reported no relief and ephedrine sulphate was substituted. On this regimen he had very little trouble for the next four months.

Third admission: December 8, 1953. Patient reports repeated syncopal attacks now with occasional convulsions during past month. Blood pressure: 170/90. No attacks were observed since admission the day before. Pressure on left carotid sinus resulted in loss of pulse, blood pressure and a convulsive seizure. Procaine injection of carotid sinus and stripping of nerve plexus were again proposed but refused by patient. No new neurologic signs were elicited. On December 10 he appeared drowsy and refused his tray. The next day he had several fainting spells on turning his head. The following day, December 12, patient was found in a stupor. He was dyspneic and cyanotic with a feeble, slow and irregular pulse. In spite of usual resuscitatory measures including oxygen, epinephrine, atropine, and digitalis, his condition deteriorated and he was pronounced dead about three hours later.

Autopsy Report: At autopsy the body measured 69" in height and weighed 167 pounds. There was extreme cyanosis of the lips, nail beds and lobes of the ears. A midline suprapubic scar extended 8.0 cm. above the symphysis. The pupils of the eyes measured 7 mm. in diameter and were equal. Within the peritoneal cavity there were dense adhesions in the region of the suprapubic scar and laterally about the neck of the bladder. The vessels of the superior mediastinum were dilated and engorged. There were a considerable number of adhesions over the posterior and lateral surfaces of both lungs, with a nearly complete synechia of the diaphragmatic surface. The right lung weighed 633 Gm., the left lung weighed 387 Gm. On cut section the parenchyma oozed a moderate amount of foamy fluid especially in the basilar portion. The left lung appeared partially collapsed with irregular areas of reddish discoloration.

The myocardium of the left ventricle measured 3.0 cm. in thickness; that of the right measured 1.0 cm. in thickness. The valvular system showed some increased nodularity on the tricuspid and mitral valves but no evidence of functional stenosis or insufficiency. Dissection of the heart chambers revealed weights as follows: Right ventricle 74 Gm., right ventricular fat 25 Gm., left ventricle 150 Gm., left ventricular fat 25 Gm.

Since the heart weights were well within normal limits it was felt that the increased thickness of the myocardium was the result of systolic contraction rather than actual hypertrophy.

The coronary arteries showed moderate arteriosclerotic changes but no evidence of old or recent occlusion. There was a considerable amount of arteriosclerosis diffusely scattered throughout the length of the aorta but no significant changes in the major branches.

There were a number of confluent erosions in the esophagus. A small cystic diverticulum was found in the jejunum in the region of the papilla of Vater. A number of diverticula were scattered along the colon. The liver weighed 1,193 Gm., and showed evidence of passive congestion. The

kidneys were not grossly remarkable. The rest of the organs were not grossly remarkable.

Dissection of neck revealed no gross tumor or other abnormality at or near carotid bifurcation. Skull was not opened.

#### COMMENT

Fainting is a clinical manifestation of many etiologies. Among the most common are:

1. Vasodepressor syncope (common fainting)—arteriolar dilation.
2. Postural hypotension—vasodilatation instead of normal vasoconstriction on standing.
3. Adams-Stokes attacks—cardiac arrest with cerebral anemia.
4. Calcified aortic stenosis.
5. Hyperventilation syndrome.
6. Hypoglycemia.
7. Cerebral pathology—petit mal, brain tumor, etc.
8. Carotid sinus syndrome.

In the case described this differential diagnosis was explored. All but the last were ruled out on the basis of negative supporting findings and affirmatively by response to pressure on carotid sinus which was prompt and repetitive. The increase in frequency of paroxysms as well as their intensity resulting in the final admission in convulsions appears to bear out the contention of the late Soma Weiss that arteriosclerosis is probably a strong predisposing factor in hyperactivity of the carotid sinus. The autopsy report failed to disclose an adequate organic cause of the syncopal attacks. Because permission to examine the brain was refused it was impossible to eliminate a cerebral vascular lesion as the final precipitating factor in the demise of the patient. If this were present one might conjecture as to the contributory effect in the local circulation of the frequent episodes of cerebral anemia conditioned by the sensitive carotid sinus.

#### ACKNOWLEDGMENT

Grateful acknowledgment is made to Dr. A. F. McGourty, who was the referring physician, and to the Pathological Department of the Stamford Hospital, Dr. W. M. Layton, Jr., director.

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## WHAT GOES ON IN A MODERN HOSPITAL

### A Declaration of Interdependence

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TO THE title set for me I have taken the liberty of adding a subtitle: A Declaration of Interdependence.

I wish to speak first about some of the administrative aspects of hospital work, and then about some of the aspects that are related to the private practice of medicine.

The hospitals are trying to keep up with this energetic world. They are trying to make their thinking measure up to their ever increasing responsibilities. And they are doing their best to see to it that their thinking does not evaporate into nothingness, but is followed closely by action.

New thinking does not necessarily mean a departure from time-tested principles. It means new ways of carrying out old principles. You have observed all this going on—sometimes with approval of the modes of application, sometimes with doubt, sometimes with disapproval, and, I fear, too often without being given an opportunity of adding your own thinking to the general fund of thought.

I am one of those who expect that this last defect will be corrected. The burden of correcting it rests upon us laymen. We have been too bashful, too hesitant in making the proper advances, too much restrained by the superstition that hospital relationships are delicate. Nothing in the world is delicate until somebody calls it so. Let us thrust aside the barriers and step forth to meet face to face on common ground as the men of integrity that we are, of good will, of tolerant minds, and with a great need of knowing one another's thoughts. In human affairs there is no substitute for the rubbing together of honest minds.

What I have said so far applies in the most general way to the total substance and character of the hospital as an integral part of the fabric of society. You might describe it as hospital statesmanship.

If we pay due respect to the adage that "actions speak louder than words," we shall place our first emphasis upon the practical questions of internal administration, the patient, careful carrying on of

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#### SUMMARY

In the administrative aspects of hospital work the defects, even to the last one, should be corrected by the laymen. This constitutes hospital statesmanship and can only be effected in the proper atmosphere. The difficult function of the hospital administrator is emphasized. There must be cooperation and coordination among the various department heads.

The selection of physicians to whom the privileges of the hospital are extended rests with laymen but the responsibility of the proper practice of medicine within the hospital rests with the physicians.

The proposed functions of the Yale-New Haven Medical Center are outlined.

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the day's work. In this matter I give top importance to the atmosphere in which all that work is done, to the manner in which we all get along together. In one of our hospitals I have recently heard the proper boast that they seem to be able to get important things done without raising their voices. This does not mean that they are "too sweet to be wholesome." It means that they are considerate of one another, are tolerant of differences in opinions and methods, do not utter the impatient word. As an ideal and goal in human relations that is an achievement, and is not made less so by the inescapable lapses. There will always be lapses. Consider how often the members of even a small and devoted family, when they come down to breakfast, start the day wrong. Then consider the size of a hospital family, comprised of those who work, usually under pressure, and, more importantly, those who are sick, with their anxious relatives and friends. In such an assemblage the fallibilities of human nature have at least an average prevalence. We cannot hope to eliminate them, but there is much we can do to reduce their frequency and subdue their impact.



As in the family circle, the spirit controls. We may call it the atmosphere.

A proper atmosphere cannot merely be wished into being. To a surprising extent its sources are physical and mechanical. An animal psychologist has said that a dog does not wag his tail because he is happy, he is happy because he wags his tail. And, with a nicer feel for scientific accuracy, we have the words of an illustrious human psychologist, William James, in his chapter on emotion: "Bodily manifestations must be interposed between (the mental state and the reaction). The more rational statement is that we feel sorry because we cry, angry because we strike, afraid because we tremble, and not that we cry, strike or tremble, because we are sorry, angry or fearful as the case may be. Without the bodily states following on the perception the latter would be purely cognitive in form, pale, colorless, destitute of emotional warmth. In rage it is notorious how we 'work ourselves up' to a climax by repeated outbreaks of expression. Refuse to express a passion, and it dies. Count ten before venting your anger, and its occasion seems ridiculous. Whistling to keep up courage is no mere figure of speech. On the other hand, sit all day in a moping posture, sigh, and reply to everything with a dismal voice, and your melancholy lingers. 'Smooth the brow, brighten the eye, contract the dorsal rather than the ventral aspect of the frame, and speak in a major key, pass the genial compliment, and your heart must be frigid indeed if it does not gradually thaw!'"

A motorist is serene when the engine runs sweetly. Alas for his composure, and the composure of all his passengers, when the engine coughs and sputters!

In a hospital smoothness of operation is the indispensable element in maintaining an atmosphere of calmness and patience and a good measure of personal contentment. Such a condition is becoming more and more difficult to attain as the volume and complexity of our tasks increase, with indications that they will increase steadily in the future.

The answer lies, I believe, in the direction of a careful departmentalization of all the functions, with the heads of the various divisions selected not more for their administrative capacity than for their ability to work together in all matters where their duties overlap. To create and control such an organization is the first and continuing duty of the top administrator. How he shall do it no man should try to tell him. He will do it in his own way.

The job of the hospital administrator is one of the

most strangely trying jobs in all the world. It calls for exact technical knowledge and training on a wide variety of fronts, with a feel for what is important in still other areas. It requires an ability to turn from one problem to another without breaking his stride throughout a long day of insistent pressure, often with an evening meeting coming up. It calls equally for deftness in administrative touch and a granite firmness in final decision. It calls for human understanding. It calls for unshakable fortitude of mind and spirit. To paraphrase a celebrated poem: "And, what's more, you'll be a hospital administrator, my son."

In the practical conduct of hospital affairs I have sometimes wondered if those of us who try to serve as advisers and policy makers are not too much inclined to let discussions smother us, to allow conferences to dissolve into drifting vapors. To me the palliative is action. Discussion is essential to get the facts presented and the objectives agreed upon, but let no conference end until a course of action has been determined. It may be recessed for a cup of coffee or a night's sleep, but not adjourned to some possible future call of the chairman.

Action is a powerful solvent of problems. It has the merit of being a tangible thing that can be shaped and reshaped like clay in the hands of the sculptor; and the consequences of action are less likely to be adverse than the consequences of prolonged inaction, provided always that those concerned are united to work together effectively and pleasantly. Such a process might be termed test by action.

Now you have a right to ask me to make my words about "action" something more than academic. Here in the bosom of the professional family I do not hesitate to do so. In the hospital where I work we have not been any freer than others from the perplexities consequent upon the tightness of the supply of nursing care. To that situation we have, of course, given top priority in all our thinking, in most of our discussions, and in a variety of specific separate actions. But recently our director, in conjunction with the director of nursing, pointed out to us that our efforts have lacked the overall coordination that might give them a greater carrying power. They suggested that we look for a way to bring all our efforts to a burning-glass focus. After the proper consultations we determined upon a course of action that would be as accurately pointed and as stoutly resolute as we always try to make our thinking.

Omitting details, I give you a brief outline. The Administration has set up what we think of as a "task force," consisting of the director and four others, of whom two are from the Board of Directors and two from the professional staff. This group is small enough to act decisively in seizing the beach-head, and large enough to hold it until reinforcements arrive to expand it. Their duties will be to make a new and speedy study of the main components of the nursing problem. They will seek information and suggestions from all responsible sources, outline a possible course of action, and use their influence to the end that a comprehensive program shall be started as soon as possible and pursued unremittingly. It means the marshaling of all we have and are into coordinated and vigorous action. Let me point out, as an aside, that this plan is not a superimposing upon the standing committees of still another committee, a committee to end all committees! The members will function as delegates of the Executive Committee of the Board of Directors and the Executive Committee of the general staff, and will hold themselves accountable to those two committees.

I must not omit one possible by-product from which I have great expectations of good—that, as a result of asking for the best thought and the active cooperation of all those who care, there may be more and more who will say "we" instead of "they."

So much for the hospital aspects. As I come to the aspects that are related to the private practitioner I compare myself to Robert Burns' Mouse—

"Wee, sleeket, cowrin' tim'rous beastie,  
O, what a panic's in thy breastie."

But the roof is off my nest, and I see no escape. Moreover, it will serve me right to have to observe my own admonition as to presumed "delicacy."

We can start with certain assumptions upon which we can surely agree, treating them as facts or, as the lawyers say, stipulations:

First, the health of the community depends upon the private practitioners. No institution can do more than be their supplement. Hospital buildings can never fill the place of the private office and the visit to the home. Let that massive fact be the core of everything we do and everything we plan.

Recently I took a taxi to Howard Avenue. When told my destination the driver made a comment, and I encouraged him to continue. This is the substance of what he said: "It is wonderful to have a hospital

when you need what it alone can give you, but it is even more wonderful to be able to call a private doctor to your home. He sees you in your own surroundings, and in their light he judges your trouble. He talks with members of your family. He listens when you talk about your worries. He gives you comfort and a sense of peace and hopefulness. If he tells you to go to a hospital, you know that is the thing to do. He arranges for your admittance, and attends you while you are there. He is your understanding friend as well as your trusted medical man." He ended by saying, "We could not get along without such men."

A second assumption is that the laymen connected with the hospitals are coming to have a more and more definite understanding of their duties. Always with an ardent desire to do their part they have been bothered in the past by a vagueness as to what that part was. My observation is that the laymen and the doctors alike have hesitated to ask for a showdown on that matter. Therein is a good example of a supposed "delicacy" which evaporates under the sunlight of good-tempered discussion. Laymen everywhere will be relieved when they realize the truth that it is no part of their duties to tell doctors how to practice medicine, but that their obligation in that respect will have been fulfilled when they themselves have faced boldly, and have carried through, the grave duty of selecting doctors of established character and superior ability, giving to them the responsibility and the authority to maintain throughout the institution uncompromising standards of medical and surgical practice. To that end each hospital will formulate its own procedures, and in its own particular way will establish the mechanism, not only to get all its daily work effectively and smoothly done, but equally to make sure that every procedure will contribute to meeting the just necessities and the working convenience of the private practitioners and their patients. That is the be-all and the end-all of hospital statesmanship.

At this point I think it appropriate that I give you my own thoughts concerning what now bears the formal designation of The Yale-New Haven Medical Center. I was glad when the time came that we could all agree to give this expressive name to the great aggregation of functions in which each of us is called upon to take so vigorous a part.

From Hippocrates down through more than twenty centuries medical men have been faithful to



the trinity of healing, teaching, and research. Every doctor, in his daily attention to healing, seizes every opportunity to help younger doctors to learn. Every doctor, both from necessity and in response to his impulses, is an avid seeker of new knowledge. He is a researcher in his own right.

Here in New Haven County, ever since the first settlement, devoted men have been creating the essentials of a medical center of superlative quality, and they have made steady progress in coordinating all the components. The determination to give to those collective efforts a definite name and a clear objective provides a rallying point that is sure to be gloriously productive.

All our thinking of recent years concerning the formalities of a medical center, and all our conferences and discussions, have made it plain that no group is seeking an advantage over any other group, or would tolerate any arrangement that did not constitute an equal and honorable partnership among men of conscience and dignity.

It is natural that, in the developments of the past few years, there should have been some wondering, some uncertainty, even some doubts. These seem to me to have grown gradually less. I hope, and truly believe, that they will largely vanish. Of one thing we can be sure: the directors of the Hospital and the authorities of the University are united in the determination to play fair.

The Medical Center means the following things:

1. A strengthening of the concept of the Hospital as a supplement to the private practitioner in his care for the health of the community. In this connection I am sure that you would wish me to emphasize again the importance to the individual doctor of being able to conduct his practice in surroundings alive with opportunities for studying new procedures and for keeping instantly informed about the latest concepts of medicine. Such opportunities are found at their best in a large hospital working harmoniously with a robust school of medicine.

2. An improved and intelligent amplification of public relations between the institution and the community, with an affirmative coordination of plans for future development as they may, from time to time, be prescribed. We are fortunate in having found the right man to act as director of Program Development. He will assume office a week from today.

3. A businesslike and coordinated approach to the large and continuing problem of obtaining from all sources, both local and nationwide, the capital funds that are vital to progress.

The Medical Center does not mean, nor in any way does it imply, the following things:

1. Any curtailment, or danger of curtailment, of the opportunities and privileges of the private practitioners.

2. Any unbalancing extension of "private practice" by the full time staff.

3. Any radical changes in the philosophy governing the general staff.

Such are the broad outlines of our mutual covenant. Our mutual task will be to fill in all the details as we go along, day by day and year by year. As I appraise our collective mind I find myself serene in the belief that we shall all be able to keep the faith, adjusting the details of our procedures to ever varying circumstances but clinging passionately to the fundamental principles.

You in your practice and we as laymen in the hospitals are fortunate in having one common objective that is as clear and unfailing for us as the North Star is for the mariner. It takes only five words to state it: the health of the individual. In the struggle for the optimum of health for every individual you are on the front line. We shall try hard to be ready whenever you need us.

In New Haven County we are all deeply conscious of the heritage we have from former generations. From what they did we can draw the courage to do all the things required of us in our own span of years. A few days ago Dr. Levy quoted to me some verses from "Ulysses." (And most of you know how Dan Levy can quote, all the way from Aristotle down through Marcus Aurelius and Shakespeare and Swinburne to T. S. Eliot.) When I got home I asked my wife for her copy of Tennyson and I found these lines, which I lift from their surroundings and give to you as fragments:

"There lies the port; the vessel  
puffs her sail . . .  
Come, my friends, . . .  
Push off, and sitting well in  
order smite  
The sounding furrows.  
One equal temper of heroic hearts,  
. . . strong in will  
To strive, to seek, to find,  
and not to yield."

# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### Thanksgiving

"As the colors of autumn stream down the wind, scarlet in sumac and maple, spun gold in the birches, a splendor of smoldering fire in the oaks along the hill, and the last leaves flutter away, and dusk falls briefly about the worker bringing in from the field a late load of its fruit, and Arcturus is lost to sight and Orion swings upward that great sun upon his shoulder, we are stirred once more to ponder the Infinite Goodness that has set apart for us, in all this moving mystery of creation, a time of living and a home. . . .

"In such a spirit I call upon the people to acknowledge heartily, in friendly gathering and house of prayer, the increase of the season nearing its close: the harvest of earth, the yield of patient mind and faithful hand, that have kept us fed and clothed and have made for us a shelter even against the storm. It is right that we whose arc of sky has been darkened by no war hawk, who have been forced by no man to stand and speak when to speak was to choose between death and life, should give thanks also for the further mercies we have enjoyed, beyond desert or any estimation, of Justice, Freedom, Loving-kindness, Peace—resolving, as we prize them, to let no occasion go without some prompting or some effort worthy in a way however humble to those proudest among man's ideals, which burn, though it may be like candles fitfully in our gusty world, with a light so clear we name its source divine."

These lines written over a decade ago by a former Governor of Connecticut affectionately known as Uncle Toby are still as poignant today as they were then, and they should serve to remind us of the

privileges we enjoy as a free profession, free to practice what seems best for our patients and free to exercise our ingenuity to the utmost.

### Practical Points About Diabetes

This year's Diabetes Detection Drive of the Connecticut Diabetes Association is November 14 to 20. During this time it is hoped that each doctor will test the urine for sugar on each patient that he sees. Past drives have shown positive urine tests in one to two per cent of those tested.

Each positive test found in the drive will be referred to the family doctor for confirmation and no positive test for sugar should be dismissed lightly. In the recheck the sample should be obtained two hours after a heavy meal and not by a random specimen. If this is found positive, a blood for sugar should be taken right then; if one waits to send the patient to the laboratory the next morning, he will already be on a diet and besides a fasting blood may be normal in a mild diabetic. If the blood sugar is normal, the patient should be urged to be on a normal food intake but submit for testing a urine specimen obtained two hours after a main meal and this should be repeated several times.

The diagnosis of diabetes is confirmed by an elevated blood sugar with sugar in the urine. If this can be found by after-meal tests, it saves trouble and expense. When in real doubt a glucose tolerance test should be done.

The glucose tolerance test is a valuable but little understood instrument. In the first place it is a diagnostic test only and tells nothing of severity of the diabetes or the requirements of the patient. It



should never be done on a patient who already has had an elevated blood sugar with sugar in the urine. It is an insult to his diabetes.

The first requirement for a glucose tolerance test is that the patient should be on a normal diet of at least 300 Gm. of carbohydrate for at least three days. This test properly done can usually be depended on to clear up the diagnosis in a doubtful case but even this test is not always clear cut. Then the patient should be watched by testing occasional samples of urine collected two hours after a main meal as the morning urine is positive for sugar only in the fully developed diabetic.

When the diagnosis of diabetes is established, treatment has two important phases, the control of the diabetes and the education of the patient to live with his diabetes comfortably.

In treatment, diet is first and must be prescribed in accordance with the age, sex, occupation and nationality of the patient. The assistance of a dietitian should be sought or the use of special equipment as the "Meal Planning and Exchange Lists" used in many hospitals. It must be a livable diet even in the obese diabetic needing reduction and it must be explained to the diabetic and the person preparing his meals. If the urine is heavily positive for sugar or not readily cleared by diet, insulin should be started at once. It is much better to omit it later than to start it only when the sugar is far out of control. The testing of urine for sugar is the indicator for balancing the dietary needs against the insulin requirement. This testing should become a diabetic's lifelong habit. The education of the diabetic must start with diet, urine testing, and insulin administration and continue with each visit to include the results of dietary indiscretions, insulin reactions, acidosis, care of skin and feet and extend even to the complications which come with time. The early and careful and continued control is the only hope of postponing the eventual complications of this chronic metabolic disturbance. The diabetic will take his handicap no more seriously than his physician and has no other source of learning about his variation from normal.

### The Antibiotic Problem

Ever since the discovery of the sulfonamides and penicillin the number of antibiotics has increased by leaps and bounds. At first thought to be a boon to physicians, the plethora of antibiotics has come

to pose a real problem to the practicing physician. Each mail brings a deluge of advertisements from the pharmaceutical houses adding to the physician's bewilderment. Antagonistic and synergistic reactions as well as sensitivity have developed. Instead of a clear cut choice of any one antibiotic being the case, the confusion as to choice of the proper drug has increased.

Elsewhere in this issue our readers have the opportunity of reading an up to date discussion of the entire problem. Dr. Bennett describes all the facets of the picture in clear language which should be welcomed by every one in practice. His conclusions are based on experience and will go far in pointing the way and clearing the confusion.

### Inspection of Osteopathic Schools

Last June at the annual session of the House of Delegates of the American Medical Association several resolutions relating to the osteopaths were introduced. No action on these was taken but at the same session the Committee for the Study of Relations Between Osteopathy and Medicine, headed by AMA Past President John W. Cline, was submitted. This progress report was accepted by the House.

The Committee's three page typewritten report said that "the justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The Committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations Between Osteopathy and Medicine to visit schools of osteopathy for this purpose."

Two other important paragraphs of the AMA's Committee report said:

"It was agreed that each school would be visited by two members of the Committee, accompanied by an individual of established experience in inspection of medical schools. The studies would be of sufficient duration, breadth and depth to establish the nature and scope of the educational program and determine the quality of medical education provided.

"The Conference Committee favorably recommended this proposal to the Board of Trustees of the

American Osteopathic Association which considered it at a special meeting on February 6-7, 1954. It has referred the question to the House of Delegates which will act upon the proposal at its Toronto meeting in July. If the action of the House of Delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year."

The action of the House of Delegates of the American Osteopathic Association was favorable. The Association issued a statement setting forth the action of its delegates. It is so important to our study so far that it is quoted herewith in full:

"The House of Delegates of the American Osteopathic Association in session in Toronto, July 15, 1954, directed the Conference Committee to continue in its deliberations with the committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association.

"In expressing its confidence in the four years' work of the AOA Conference Committee, the House agreed that the Committee should have the authority to negotiate with the AMA Committee on possible visitation by the latter of osteopathic colleges. The purpose of this visitation would be to observe the nature and scope of their education programs. This observational opportunity would be conducted entirely within limits agreed upon by the two committees. The immediate purpose of such on-campus visitations is to provide information to the AMA Committee to assist in its efforts to remove the cultist designation from the osteopathic profession.

"The House of Delegates of the AOA in its approval of such visitations has established no new precedent, except that the proposed visitations would permit a private agency to determine for itself osteopathic educational programs and procedures. A much wider permission has long been afforded to official state examining agencies, granting agencies of the U. S. Department of Health, Education and Welfare, and other official groups, to visit osteopathic schools. If the AOA Conference Committee permits observation of osteopathic colleges by a private agency, it does so on the basis the American Osteopathic Association has long indicated its willingness to cooperate with the authorized group of any profession, 'wherever that cooperation may be expected to improve the health service offered the public.'

"Approval or accreditation of osteopathic colleges is entirely without the province of observational bodies and any visitations by the Committee on Relations Between Osteopathy and Medicine, if made, will be made purely for the purpose of affording a private agency an opportunity to inform itself about osteopathic educational programs.

"In commenting on this action, the newly elected President of the American Osteopathic Association, John W. Mulford, D.O., of Cincinnati, stated that the action was taken by the House of Delegates 'with the complete confidence that neither the osteopathic profession nor the medical profession wishes to inflict its officialdom on the other.' He went on to say that the action of the AOA House of Delegates could be considered as 'a logical outgrowth of the mutual respect which the two schools of healing hold for each other'."

Doctors of medicine will watch with interest the result of these on-campus visitations of osteopathic schools. The results should go far to answer the question, "Should modern osteopathy be classified as 'cultist' healing?" It is obvious that if the Committee finds the term cultist no longer applicable, there no longer will be any question as to whether or not doctors of medicine should teach in osteopathic schools or consult with doctors of osteopathy.

The House of Delegates of the American Osteopathic Association is to be congratulated on its favorable action to the Conference Committee's proposal for an inspection of its schools. It is an evidence of good faith which had previously been denied organized medicine and should help materially in bringing about a solution to the now unsettled relationship of the doctor of osteopathy and the doctor of medicine.

### The Perennial Problem of Quackery

The word quack is an abbreviation of the old Dutch word quacksalver, literally a man who boasts of his healing salve now come to mean "an ignorant pretender to knowledge or skill of any sort." When a physician speaks of a quack he visualizes an individual who pretends to be a doctor of medicine, forgetting perhaps that there are legally qualified members of the profession, small in number it is true, who use quackish methods. Within the past two years the writer had a friend and neighbor with cancer of the stomach who put herself into the



hands of a licensed physician who claimed to have a cure for cancer, and after her husband had paid exorbitant fees to the charlatan, died of the disease. Presumably reputable newspapers and magazines still sometimes carry advertisements of obvious quacks. It is also true that no hard and fast line can be drawn between cultism and quackery for cultists advertise and make unfounded and extravagant claims regarding the results of their particular techniques.

In a recent article Aytoun Ellis\* dates obvious quackery among the English speaking peoples to the time of the Roman occupation of Britain when a quack named Junianus claimed that he had an eye salve "most effective for clearing the sight" which he described as "the very medicine of Phoebus Apollo." It was not until 2,000 years later that quackery became widespread in London where large numbers of these impostors preyed on the credulous of all ranks of society including even royalty.

It is usually easy to recognize the earmarks of quackery. The quack always makes extravagant claims for his remedy; he advertises, sometimes openly in the press, sometimes obliquely by driving showy equipages or by offering well known diagnostic procedures at a ridiculously low price in order to get the suckers into his net. Naturally he claims successful cures, and usually emphasizes that his methods are painless and unaccompanied by risk.

Most States have sections in the laws governing medical practice which permit the revocation of the license of practitioners who can be proved to use quackish methods. The elimination of unlicensed quacks is more difficult, especially as most of their victims do not wish to be shown up as suckers. There seems to be a vein of credulity in most human beings, though some who have been carefully examined by competent doctors and have learned that they are victims of some incurable disease resort to quacks in despair. The problem is, like many other problems, one of education.

G. B.

\*Courier, London, 1953, 21:77.

## Arthritis Strikes Those Who Work Hardest

Arthritis flourishes and is aggravated by mental and physical stress and strain as well as by anxiety and shock.

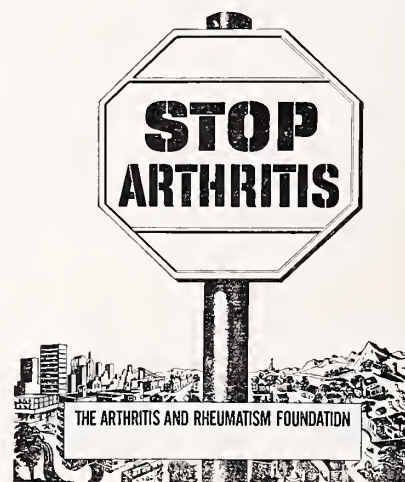
And as a result, more than 150,000,000 work days were lost to the nation last year because of the Nation's No. 1crippler.

Statistics show that more machine operators out in the factory come down with arthritis than do the clerical workers in the front office. Yet, on the other hand, officials of the company are a bit more prone to suffer an arthritic breakdown than their office personnel.

Perhaps the answer to this paradox is simply that people who work the hardest are more prone to fall victim to the pain and miserable disease. And one can work just as hard mentally as one can physically.

Besides, case histories indicate that heredity, fatigue, lowered physical resistance and emotional stress and strain contribute to the cause of arthritis. Injury, shock, poor personal hygiene, exposure to dampness and cold and chronic infections may be other contributing causes.

The Arthritis and Rheumatism Foundation nationally sponsors the basic and clinical research that may some day answer such questions as these and thereby help prevent and perhaps even stop arthritis.



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## THE HISTORIAN'S NOTE BOOK

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### MEDICAL FEES IN BRISTOL

ARTHUR S. BRACKETT, M.D., *Riverside*

WHEN I first came to Bristol in November, 1896 I had my office at 337 North Main Street opposite the office of the E. Ingraham Company, telephone 27-3. My office consisted of two rooms. The smaller in the rear was my consultation room. The larger my waiting room. It was furnished with two or three chairs and a lounge where I slept at night.

I had expected to wait weeks before I had any patients. So the first afternoon when the bell rang and my landlady ushered a well dressed lady in, I was much surprised and delighted. She said, "Is this Dr. Brackett?"

I said, "Yes."

"Well," she said, "I represent the Society for the Prevention of Cruelty to Animals and we would like a contribution."

Well I thought, "I'm over my ears in debt and another dollar won't make much difference," so I gave her a dollar.

She came around every year after that. But believe it or not when her own doctor died in Hartford she called on me in Bristol and when she was sick in Hartford called me from Bristol. In the end she gave me more dollars than I did her.

My next caller came down from Burlington to see its new doctor. As was generally the case she was in the class where either she had made the rounds of many doctors without cure, or she had not paid any of them and had to go to someone who did not know her financial standing. I, of course, did not know anything about her, but assumed that she was sick and could pay for professional services. Anyway, I was glad to greet her even if she had nothing. She told a long tale of woeful symptoms for a long time. I gave her a pill for every symptom. (Bristol was predominantly a homeopathic town where the doctor furnished the medicine.) At last she said, "How much do I owe you?"

I said, "Fifty cents."

"But," she said, "I have only 38 cents."

"Well," I said, "why not pay me the twelve cents the next time you come down from Burlington?" I don't remember whether she did or not.

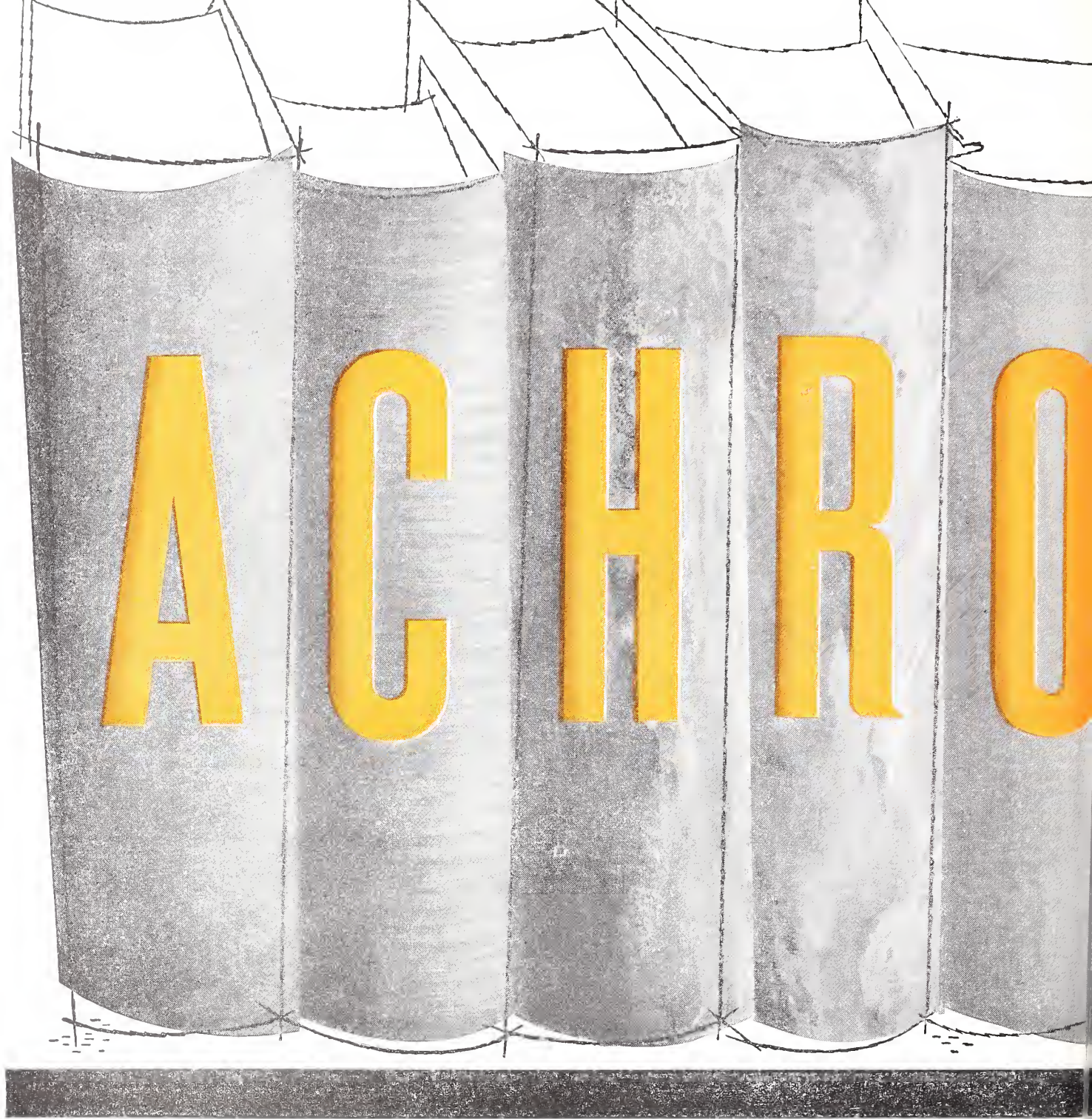
Sometimes we were paid in old hens or other farm produce. I remember one patient who worked around the house quite well. But generally patients paid me in money or nothing.

For the first six months I either walked or hired a team from a stable. Later I used a bicycle. Fifty cents for office calls and one dollar for house calls seems very low pay, but with that one dollar I could get a man to work for me for ten hours a day, and think he was fortunate. It was told as a great joke that when a man from New Britain applied for work, he was offered \$7 a week for a six day week. "No sir," he replied indignantly, "a dollar a day." It is needless to say that he was hired.

The value of anything bought is determined by the quality and quantity of what you get for your money. The medical profession sells health. Our overhead then was low, but we had to work long hours with short or no vacations. It was impossible then to give as much as we do now in effective treatment. I remember stopping to rest at the foot of Tom Martin's hill on Farmington Avenue after I had been making a call in Edgewood with my bicycle. I never felt so rich, then or since, in my life for I had \$28 in my billfold!

But why write about what was happening only about fifty years ago in medicine? Because there have been more changes in the last fifty years than in hundreds of years previous to that time. We had no hospital in Bristol. Diphtheria anti-toxin had been discovered but was little used. The same was true for the x-ray. We knew little about vitamins, and nothing about the sulpha drugs or the antibiotics. But while we seem to have been paid very little we actually gave very little in return. We knew more about our patients environment; cases of osteocephaly were as prevalent then as now (even though perhaps, one was not born every minute).



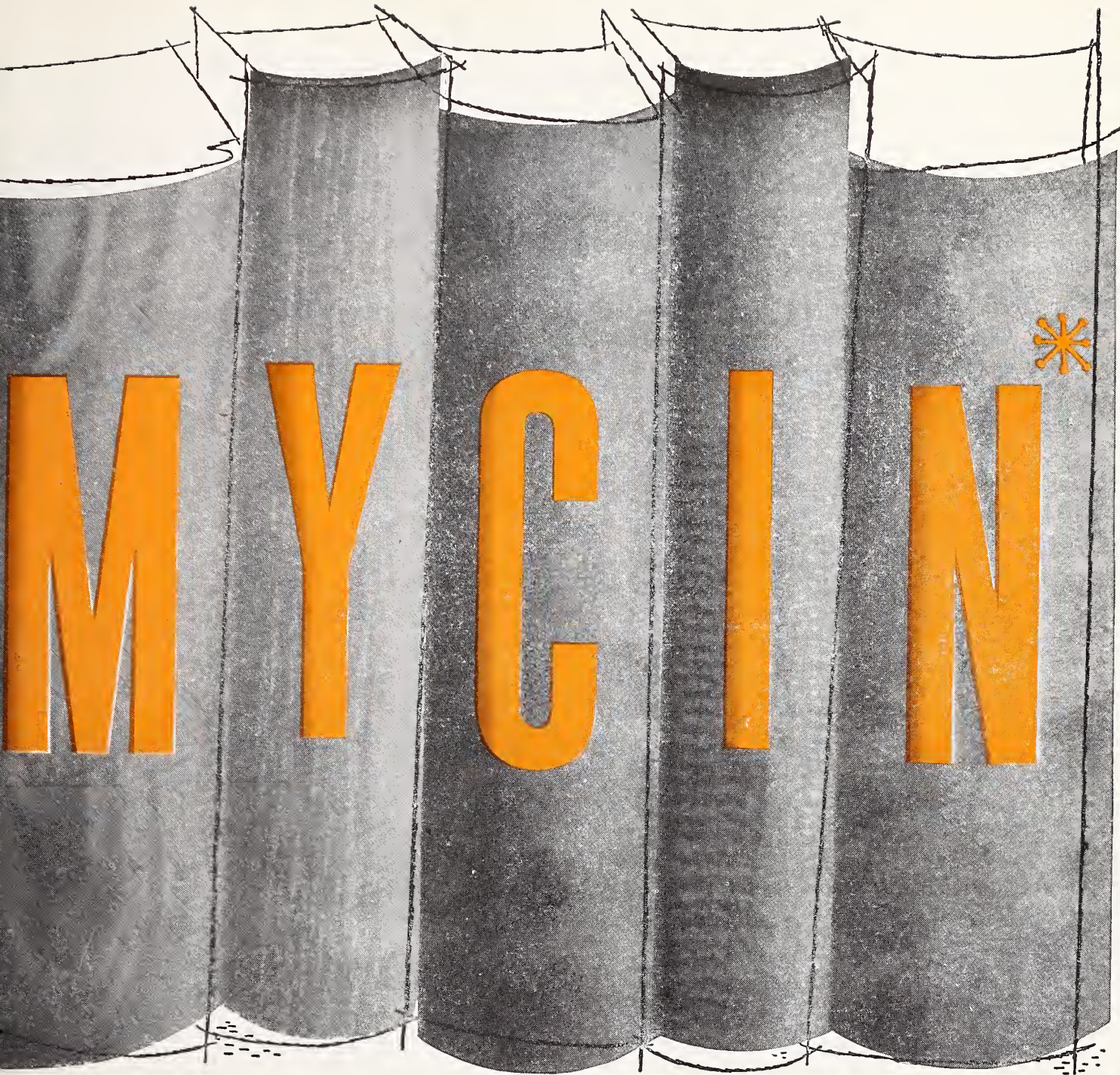


*Medical history is being written today*



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November, 1954

## THE POETRY OF SLEEP

ONCE again the temptation to devote this page to a nonmedical subject proves irresistible; once again a deep interest clamors for expression. One cannot hope to illustrate the glories of poetry by means of a few brief quotations, but even a pitifully inadequate attempt may serve to acknowledge a lifelong indebtedness. The topic above was chosen because in this season of the year the thoughts of many turn gratefully to crisp evenings, open fires, longer nights of quiet sleep. Physicians have reason to know that most people regard peaceful sleep as one of life's greatest blessings, and its absence as unqualified torment.

The selections below are those chosen from more than fifty originally gathered for this page. They cover a period of almost twenty-five centuries: from about 500 B. C. to our own generation. In most instances only short excerpts are given. They are arranged in order of publication date when that is known; otherwise in order of the birth dates of the authors.

Those who believe that our own restless age places disproportionate emphasis upon sleep may be interested to learn that it has concerned thoughtful writers and poets throughout recorded history.

O soothing sleep, dear friend, best nurse of sickness!  
How sweetly came you in my hour of need.  
Best Lethe of all woes, how wise you are,  
How worthy of the prayers of wretched men!

*Euripides (480-406 B. C.): Orestes and Electra.*

What sin was mine, sweet, silent boy-god, Sleep,  
Or what, poor sufferer, have I left undone,  
That I should lack thy guerdon, I alone? . . .  
Come hither, Sleep. Let happier mortals gain  
The full embrace of thy soft angel wing;  
But touch me with thy wand, or hovering  
Above mine eyelids sweep me with thy train.

*Publius P. Statius (61-96 A. D.): Trans. W. H. Fyfe.*

The toil of day is ebbing,  
The quiet comes again,  
In slumber deep relaxing  
The limbs of tired men.  
And minds with anguish shaken,  
And spirits racked with grief,  
The cup of all forgetting  
Have drunk and found relief.

*Prudentius (348-405 A. D.): Trans. H. Waddell.*

Thrice happy Sleep!  
The antidote to care.  
Thou dost allay the storm  
Of grief and sore despair;  
Through the fast-closed gates  
Thou stealest light;  
Thy coming gracious is  
As Love's delight.

*MS of Benedictbeuern: Trans. H. Waddell.*

O Sleep, O tranquil son of noiseless Night,  
Of humid, shadowy Night; O dear repose  
For wearied men, forgetfulness of woes  
Grievous enough the bloom of life to blight!  
Succor this heart that hath outworn delight,  
And knows no rest; these tired limbs compose;  
Fly to me, Sleep.

*Giovanni della Casa (1503-1556): Trans. J. A. Symonds.*

O gentle sleep, O blest and blissful night,  
Ye kind dispensers of tranquillity,  
Beguile me in my dreams with false delight.  
If I may not know love's reality,  
Grant me the semblance of it, that I may  
Possess in dream the boon I lack by day.

*Louis Labe (1526-1566): Trans. Alan Conder.*

Come Sleepe! O Sleepe, the certaine knot of peace,  
The baiting-place of wit, the balme of woe,  
The poore man's wealth, the prisoner's release,  
Th' indifferent judge betweene the high and low . . .  
Take thou of me smooth pillowes, sweetest bed,  
A chamber deaf to noise and blind of light,  
A rosie garland and a weary hed: . . .

*Sir Philip Sidney: Astrophel & Stella, (1591).*

Innocent Sleep,  
Sleep that knits up the ravel'd sleeve of care,  
The death of each day's life, sore labor's bath,  
Balm of hurt minds, great nature's second course,  
Chief nourisher in life's feast.

*William Shakespeare (1564-1616): Macbeth.*

O sleep, O gentle sleep,  
Nature's soft nurse, how have I frightened thee,  
That thou no more wilt weigh my eyelids down,  
And steep my senses in forgetfulness?  
*William Shakespeare (1564-1616): Henry IV.*

Art thou poor, yet hast thou golden slumbers?  
Oh sweet content!  
Art thou rich, yet is thy mind perplexéd?  
Oh punishment!  
*Thomas Dekker: The Happy Heart (1600).*

Sleep is a reconciling,  
A rest that peace begets;  
Doth not the sun rise smiling  
When fair at eve he sets?  
*John Dowland (1603).*

Come, Sleep, and with thy sweet deceiving  
Lock me in delight awhile;  
Let some pleasing dreams beguile  
All my fancies: that from thence  
I may feel an influence  
All my powers of care bereaving!  
*John Fletcher (1607).*

Sleep, Silence' child, sweet father of soft rest,  
Prince, whose approach peace to all mortals brings,  
Indifferent host to shepherds and to kings,  
Sole comforter of minds with grief oppressed.  
*William Drummond: (1585-1649).*

Dear Night! This world's defeat,  
The stop to busie fools, Care's check and curb,  
The Day of Spirits, my Soul's calm retreat  
Which none disturb . . .  
*Henry Vaughan (1622-1695).*

Close now thine eyes and rest secure;  
Thy soul is safe enough, thy body sure;  
He that loves thee, he that keeps  
And guards thee, never slumbers, never sleeps . . .  
Then close thine eyes and rest secure;  
No sleep so sweet as thine, no rest so sure.  
*Francis Quarles (1632).*

What's to sleep?  
'Tis a visionary blessing;  
A dream that's past expressing,  
Our utmost wish possessing. . .  
*John Gay, "Polly", 1729.*

Deeply have I slept,  
As one who hath gone down into the Springs  
Of his existence and there bathed. . .  
I awaked, and my sleep was sweet to me.  
*Author and date unknown. Quoted by Walter de la Mare.*

. . . And could not win thee, Sleep, by any stealth:  
So do not let me wear tonight away:  
Without Thee what is all the morning's wealth?  
Come, blessed barrier between day and day,  
Dear mother of fresh thoughts and joyous health!  
*Wordsworth (1770-1850).*

Ere on my bed my limbs I lay,  
It hath not been my use to pray  
With moving lips or bended knees;  
But silently, by slow degrees,  
My spirit I to Love compose,  
In humble trust mine eyelids close,  
With reverential resignation,  
No wish conceived, no thought exprest,  
Only a sense of supplication; . . . .  
*S. T. Coleridge (1772-1834).*

Oh magic sleep! Oh comfortable bird,  
That broodest o'er the troubled sea of the mind  
Till it is hushed and smooth! Oh unconfined  
Restraint! imprisoned liberty! great key  
To golden palaces. . . .  
*John Keats (1795-1821): Endymion.*

But first a hush of peace—a soundless calm descends;  
The struggle of distress and fierce impatience ends.  
Mute music soothes my breast—unuttered harmony  
That I could never dream. . . .  
*Emily Bronte (1818-1848).*

O Moon, O hide thy golden light,  
O night, be not so fair;  
O ye dear stars, shine not so bright:  
I would for sleep prepare.  
Mine eyes are closing wearily  
That watched the slow day's flight,  
And yet there is no rest for me  
In this enchanted night.  
*Maria Jager: Trans. Grace F. Norton.*

I have lived and I have loved;  
I have waked and I have slept;  
I have sung and I have danced;  
I have smiled and I have wept;  
I have won and wasted treasure;  
I have had my fill of pleasure;  
And all these things were weariness,  
And some of them were dreariness.  
And all these things — but two things —  
Were emptiness and pain:  
And Love, it was the best of them;  
And Sleep, worth all the rest of them.  
*Author unknown: "Vixi".*

The broad seas darken slowly in the west;  
The wheeling sea-birds call from nest to nest;  
Draw near and touch me, leaning out of space,  
O happy Sleep!  
There is no sorrow hidden or confessed,  
There is no passion uttered or suppressed,  
Thou canst not for a little while efface;  
Enfold me in thy mystical embrace,  
Thou sovereign gift of God, most sweet, most blest,  
O happy Sleep!  
*Ada Louise Martin: "Sleep".*

H. M. Marvin, M.D.



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### HOUSE OF DELEGATES — CALL FOR SEMI-ANNUAL MEETING

The Semi-Annual Meeting of the House of Delegates of the Connecticut State Medical Society will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Thursday, December 9, commencing at 4:00 o'clock in the afternoon. The purpose of this meeting is to pass upon the Society's budget for 1955 and the Council's recommendations for revision of the by-laws and other matters that may be presented.

Members of the House will be the guests of the Society at a buffet supper following the meeting.

H. M. Marvin, President

Creighton Barker, Executive Secretary

### Council Meeting

The monthly meeting of the Council was held at the offices of the Society on October 13, 1954. The meeting was called to order by the chairman at 4:00 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Marvin, Stringfield, Couch, Barker, Weld, Murdock, Gibson, Feeney, Fincke, Gallivan, Ursone, Tracy, Russell, Labensky, Gens, Buckley, Dwyer. Absent: Drs. Gildersleeve, Flaherty, Ottenheimer, Clarke, Walker, Archambault, Gilman.

It was voted that the Council on behalf of the Society, approve the Survey on the Care of the Cancer Patient in Connecticut being undertaken by the Connecticut Cancer Society and cooperate with this survey.

Action taken by the Board of Directors of Connecticut Medical Service deferring increasing the number of members of the Professional Policy Committee of Connecticut Medical Service, as was suggested by the Council, was presented. The reason for the delay in this matter is to await the report of the special committee (White Committee) of the House of Delegates that is studying possible changes in the CMS contract to broaden medical (nonsurgi-

cal) coverage. Voted to approve the action of the Board of Directors of Connecticut Medical Service and postpone making any nominations of additional members of the Professional Policy Committee.

It was reported that Dr. Louis P. Hastings had accepted appointment to membership on the Committee on Public Health replacing Henry Bunting, deceased.

The resignation of Dr. Frederick W. Goodrich, New London from the Committee on Public Health was accepted and Dr. Joseph M. Wool, New London was appointed in his place.

It was reported that Dr. William E. Bloomer, New Haven had agreed to become the chairman of the Committee on Student Members, and had conferred with the secretary in regard to the activities of the committee.

The secretary reported concerning developments relating to establishing a course in the economics of medical practice and related subjects in the Yale School of Medicine. Good progress is being made in this project and an elective course will be given third and fourth year students of the medical school and all students of the school of public health during the coming year.

It was voted that the Semi-Annual Meeting of the House of Delegates be held in New Haven on Thursday, December 9, 1954. At the close of the House of Delegates the Connecticut Branch of the President's Committee on Employment of the Physically Handicapped will present its Citation for Outstanding Service.

A resolution was presented from the Public Relations Committee to the effect that at its regular meeting on September 30, the committee voted that the activities of the American Medical Educational Foundation in Connecticut are important enough to require the full attention of an independent committee, and that the Public Relations Committee is engaged in too many projects to devote sufficient time to the AMEF affairs, and it was requested that the Council consider the appointment of an AMEF committee with budget appropriation for its activities. It was voted to approve this proposal from the Committee on Public Relations and that William G. H. Dobbs, Torrington, continue as the chairman of this new AMEF Committee and that the chairman of the Council, the president and the executive secretary confer with Dr. Dobbs concerning appointments to the committee with power to act in making such appointments.

On request of the Committee on Public Relations, it was voted to invite Mr. William A. Richardson, associate member of the society, to become an associate member of the Committee on Public Relations.

Dr. Tracy reported for the Subcommittee on Amendments of the By-Laws relating to membership on the Council of Alternate Councilors, Speaker of the House and Vice-Speaker of the House of Delegates. The proposals made by Dr. Tracy were discussed at length and it was finally voted that the subcommittee with the cooperation of the executive secretary, prepare amendments to the By-laws:

(1) That will make the Alternate Councilors, the Speaker and Vice-Speaker of the House regular members of the Council with full voting privileges;

(2) Change the quorum requirements from the present specifications to a quorum consisting of the Councilors or Alternate Councilors from four county associations and four other members of the Council.

Dr. Gallivan reported for the Subcommittee to Investigate Retirement Program for Employees of the Society. The report stated that the development of a retirement program was desirable and the committee requested permission to contact the em-

ployees of the Society to determine their wishes. The report was accepted with enthusiasm and the committee was directed to proceed in accordance with its request.

A resolution from the Committee on Medical Care of Veterans asking approval of the Council to a proposal that the committee invite the Commander of the Veterans of Foreign Wars in Connecticut and members of his staff to meet with the committee for discussion relating to the medical care of veterans. This request was approved with the provision that the chairman of the Council and other officers of the Society be invited to attend.

It was voted to approve the customary sponsorship of the Connecticut Diabetes Association Detection and Educational Drive—November 14-20.

A preliminary report on the 1954 Clinical Congress was presented by the secretary and there was discussion of the falling off of attendance at the Congress. The request of the program committee of the Clinical Congress for permission to distribute a referendum questionnaire to all members of the Society, to make a survey of membership opinion in regard to the Congress, was approved.

Forty-five student members were elected.

Next meeting of the Council will be held November 10, 1954.

The meeting adjourned at 6:00 P. M.

## The Council Recommends That the By-Laws of the Society Be Amended as Follows

New material is in italics

Article VI, Section 1, Par. 4, to read:

A Councilor *and Alternate Councilor*, who shall serve for two years, shall be elected at the annual meeting of each of the county associations in Hartford, Middlesex, New London, and Windham counties in the odd numbered years.

Article VI, Section 1, Par. 5, to read:

A Councilor *and Alternate Councilor*, who shall serve for two years, shall be elected at the annual meeting of each of the county associations in Fairfield, Litchfield, New Haven, and Tolland counties in the even numbered years.

Article VI, Section 1, Par. 6, to read:

No Councilor *or Alternate Councilor* elected by a county association shall serve more than three successive terms of two years each, but after a lapse of



one term of two years, such Councilor or *Alternate Councilor* may be eligible for re-election.

Article VI, Section 1, Par. 7, to read:

Any vacancy in the office of Councilor or *Alternate Councilor* shall be filled by the county association in which the vacancy occurs.

Article VI, Section 2, Par. 7, delete the sentence:

“. . . and, he may meet with the Council, without privilege of voting, upon invitation of the Chairman of the Council, for the purpose of discussing procedure in the House of Delegates.”

Article IX, Section 1, Par. 1, to read:

The Council shall consist of one Councilor and one *Alternate Councilor* from each county association, the President, the President-Elect, the Executive Secretary, the Treasurer, the Managing Editor of the JOURNAL, the *Speaker of the House of Delegates*, the *Vice-Speaker of the House of Delegates*, the Delegates to the American Medical Association, any member of the American Medical Association, as provided in Article VII, Section 1, of the Constitution of the American Medical Association, and a Councilor-at-large, when elected by the House of Delegates as provided in Paragraphs 2 and 3 of this section. *Each member of the Council shall have one vote.*

Article IX, Section 2, Par. 1, the last sentence to read:

“. . . Eight members of the Council, which shall include four Councilors or *Alternate Councilors* elected by four county associations and four others, shall constitute a quorum for the transaction of business.

Article IX, Section 2, Par. 2, to be deleted in its entirety:

“Each of the Councilors elected from county associations shall be entitled to cast two votes when actions are desired by the Council, and each of the other members of the Council shall be entitled to one vote.”

Article XI, Section 1, Par. 4, to read:

The dues of any member may be remitted by vote of the Council on recommendation of a county Councilor or *Alternate Councilor*.

### Student Members

Raymond J. Bagg, Jr., Windsor  
New York Medical College—Class of 1958  
Pre-Med: University of Connecticut

Cedric R. Bainton, Woodbridge  
Rochester School of Medicine—Class of 1957  
Pre-Med: Oberlin College

Jaroslav M. Bandera, Glastonbury  
University of Vermont—Class of 1958  
Pre-Med: University of Connecticut

Peter A. Benson, Uncasville  
Yale University School of Medicine—Class of 1958  
Pre-Med: Clark University

Robert D. Bolinder, Jr., Meriden  
Tufts College Medical School—Class of 1958  
Pre-Med: Tufts College

Walter A. Borden, Hartford  
New York University College of Medicine—Class of 1958  
Pre-Med: Amherst College

Ben Bursten, New Haven  
Yale University School of Medicine—Class of 1958  
Pre-Med: University of Vermont

Anthony J. Calciano, Bristol  
University of Maryland—Class of 1957  
Pre-Med: University of Vermont

Roland J. Cavanaugh, Waterbury  
New York Medical College—Class of 1958  
Pre-Med: Fairfield University

Harold O. Douglass, Jr., Greenwich  
NYU-Bellevue College of Medicine—Class of 1958  
Pre-Med: Yale University

Philip R. Fazzone, Cheshire  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale University

Carol L. Fenton, Stratford  
Yale Medical School—Class of 1958  
Pre-Med: New Jersey College for Women

Michael E. Fishman, New Haven  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale University

Edward F. Fox, Bridgeport  
New York Medical College—Class of 1958  
Pre-Med: Fairfield University

Theodore H. Johnson, New Britain  
Columbia University, College of Physicians and Surgeons—Class of 1958  
Pre-Med: Harvard University

Jerome Levy, Portland  
Albany Medical College—Class of 1958  
Pre-Med: Wesleyan University

Charles I. Lieberman, New Haven  
New York Medical College—Class of 1958  
Pre-Med: Yale University

Robert N. Margolis, West Hartford  
Tufts College Medical School—Class of 1958  
Pre-Med: Harvard University

Roland G. Martineau, Hartford  
Yale University School of Medicine—Class of 1958  
Pre-Med: University of Connecticut

Charles D. McCullough, Fairfield  
New York Medical College—Class of 1958  
Pre-Med: Fairfield University

John A. Merritt, Jr., Greenwich  
Yale University School of Medicine—Class of 1958  
Pre-Med: Dartmouth College

Lawrence G. Methot, Moosup  
Georgetown Medical School—Class of 1958  
Pre-Med: Assumption College

Charles Neave, New Canaan  
College of Physicians and Surgeons, Columbia  
University—Class of 1958  
Pre-Med: Yale University

Avrum M. Novitch, New London  
New York Medical College—Class of 1958  
Pre-Med: Yale University

Donato A. Palermino, Hartford  
Tufts College Medical School—Class of 1958  
Pre-Med: Holy Cross College

Edward L. Pendagast, Jr., Bridgeport  
New York Medical College—Class of 1958  
Pre-Med: Yale University

Charles A. Phillips, New Haven  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale University

Robert N. Pilon, Hartford  
Tufts College Medical School—Class of 1958  
Pre-Med: University of New Hampshire

David B. Propert, West Hartford  
Jefferson Medical College—Class of 1958  
Pre-Med: University of Richmond

James P. Roach, Bridgeport  
New York Medical College—Class of 1958  
Pre-Med: Fairfield University

Carmelo G. Russo, Hartford  
Hahnemann Medical College—Class of 1958  
Pre-Med: Trinity College

Joseph A. Russotto, Thompsonville  
Georgetown University School of Medicine—  
Class of 1958

Pre-Med: American International College

Robert H. Sammis, Stratford  
Tufts College Medical School—Class of 1958  
Pre-Med: Bucknell University

Vincent J. Scavo, West Hartford  
NYU-Bellevue College of Medicine—Class of 1958  
Pre-Med: University of Connecticut

John V. Schiavone, Waterbury  
Georgetown University Medical School—Class of  
1958

Pre-Med: Holy Cross College

Herman R. Schoenwald, Noroton  
Georgetown University Medical School—Class of  
1959

Pre-Med: Fordham University

John F. Summa, Waterbury  
New York Medical College—Class of 1958  
Pre-Med: Holy Cross College

Daniel R. Sweedler, Orange  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale College

Edward J. Tracey, Westport  
New York Medical College—Class of 1958  
Pre-Med: Yale University

Joseph P. Wierzbinski, III, Norwich  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale College

Andrew F. Zembko, New Britain  
Tufts College Medical School—Class of 1958  
Pre-Med: Trinity College

Stanislaus A. Bartus, Hartford  
St. Louis University School of Medicine—Class  
of 1958  
Pre-Med: Fairfield University

Floyd D. Hamilton, Simsbury  
Emory University—Class of 1958  
Pre-Med: Emory University

Joseph P. Macary, Waterbury  
St. Louis University School of Medicine—Class  
of 1958  
Pre-Med: Fairfield University

Joseph J. Michalka, III, Bridgeport  
St. Louis University School of Medicine—Class  
of 1958  
Pre-Med: University of Bridgeport



## New Members

### FAIRFIELD COUNTY

Daniel H. Adler, Westport  
 Martin R. Benjamin, Stamford  
 Walter S. Bousa, Bridgeport  
 Robert S. Cleaver, Bridgeport  
 Monroe Coleman, Stamford  
 Eugene H. Corley, Bridgeport  
 Charles A. Crown, New Canaan  
 Laszlo Csovanos, South Norwalk  
 Henry K. Cudmore, Fairfield  
 Charles P. Curtis, Jr., Fairfield  
 Paul W. Dale, Stamford  
 Stephen H. Deschamps, Bridgeport  
 Robert W. Doering, Bridgeport  
 Joseph Dugas, Bridgeport  
 Howard S. Eckels, Bridgeport  
 Jean E. Farrell, Stamford  
 James R. Fitzsimmons, Stamford  
 H. David Frank, Bridgeport  
 Marvin Garrell, Fairfield  
 Lee B. Greene, Bridgeport  
 Robert C. Joy, Danbury  
 Anthony Komninos, Stamford  
 Harold W. March, Stamford  
 John J. McGarry, Darien  
 James I. Porter, Greenwich  
 Floyd G. Robertson, Greenwich  
 Beatrice Selvin, Greenwich  
 Gordon C. G. Thomas, Stamford  
 William M. White, New Canaan  
 Charles R. Williams, Fairfield  
 Roger H. Williams, Danbury  
 Henry Zalichin, Stamford  
 Richard L. Zimmern, Stamford

### NEW LONDON COUNTY

Virginia H. Brown, Niantic  
 Francis W. Burke, New London  
 Charles F. Dyer, New London  
 George M. Flanagan, New London  
 James H. Kelleher, Norwich  
 Archy W. Lewandrowski, Groton  
 Imogene H. Manning, Norwich  
 Edward W. Miller, Jr., Norwich  
 Estelle Siker, New London

### LITCHFIELD COUNTY

John C. Polito, Winsted  
 Mary Ward, Sharon

### MIDDLESEX COUNTY

Donn C. Barton, Middletown  
 Julianna L. Burns, Hadlyme  
 Irwin M. Israel, Colchester  
 Anthony N. Lethin, Jr., Middletown  
 Arthur D. McDowell, Middletown  
 William J. Sweeney, III, Middletown

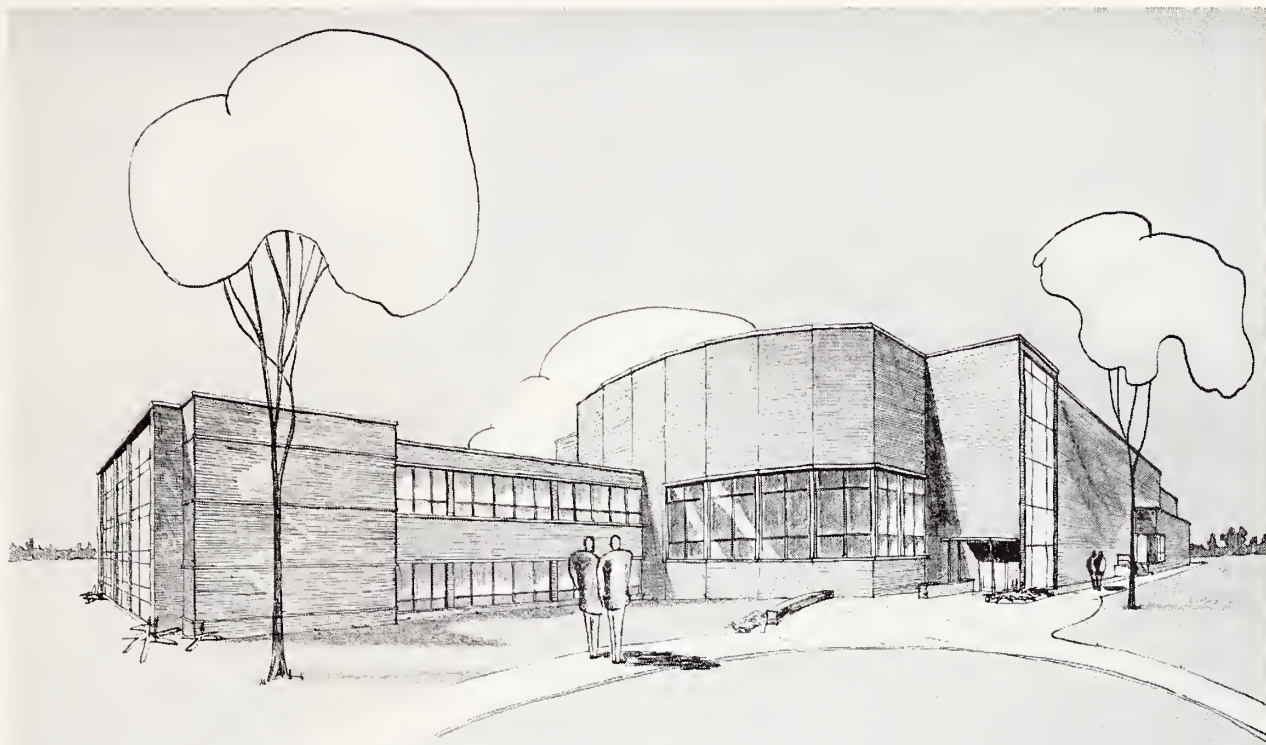
## Meetings Held During October

October 1—Board of Directors of Connecticut Medical Service  
 October 6—Committee on Hospitals  
 October 7—Committee to Study CMS Payments for Medical (Non-Surgical) Services  
 October 7—Committee on Veterans Medical Care  
 October 12—Dental Conference Committee  
 October 13—Council  
 October 14—Subcommittee on Toxemia in Pregnancy  
 October 19—Program Committee for 1955 Annual Meeting  
 October 20—Committee on Neonatal Mortality  
 October 21—Committee on Hospitals  
 October 21—Subcommittee on School Health  
 October 27—Budget Committee  
 October 27—Committee on Industrial Health  
 October 28—Medical Advisory Committee to Connecticut Cancer Society

## Former Connecticut Physicians Honored

Daniel C. Darrow, a member of the Connecticut State Medical Society and formerly professor of pediatrics at Yale University School of Medicine, at the invitation of the French Government delivered a series of lectures in a symposium on potassium therapy in Paris during June and July.

John J. Morton, Jr., formerly a member of the Connecticut State Medical Society, recently received the highest award of the Rochester Academy of Medicine, the Albert David Kaiser medal for 1954. Dr. Morton served as surgeon in chief at Strong Memorial Hospital, Rochester, New York, from 1924 to 1953, when he became professor of surgery, emeritus, and acting director of cancer research. He is now on a government mission to Japan to aid in the study of the effects of atomic radiation.



HARTFORD MEDICAL SOCIETY BUILDING  
WESTCOTT & MAPES, INC. ARCHITECTS & ENGINEERS

## Hartford Medical Society to Have New Home

Ground has already been broken for the new \$350,000 home of the Hartford Medical Society, scheduled to be completed in June 1955. The present Hunt Memorial Building has long been considered inadequate in size for the growing Society and has been sold to the Travelers Insurance Company. For 51 years after the Society was founded in 1846 meetings were held in homes of the members until through the generosity of Mrs. Ebenezer K. Hunt the present building was dedicated in 1898. At that time the membership numbered 83; now it is rapidly approaching 500.

Dr. Ebenezer K. Hunt was a distinguished ophthalmologist and a leader in his profession in Hartford. Prominent in the development of the Hartford Hospital, he made provisions in his will for both the Hospital and the Society.

The new building, also to be called the Hunt Memorial, will be fireproof, of steel frame and masonry construction with brick facing and limestone trim. It will be located near the Hartford-West Hartford line on the southeast corner of Albany Avenue and Scarborough Street. The design will be modern and it will be unique in that it will have facilities for office space, library, an auditorium and

a residence. The auditorium will have a seating capacity of 250, expendable to 300, and will occupy the three story main section of the building. Extending outward from the main building will be two wings of two stories each. One wing will house the library, consisting at present of 25,000 volumes and 180 different journals relating to medicine and allied sciences, with stock room space for 60,000 volumes. The other wing will contain offices, a lounge and storage area, and a basement apartment for the caretaker. Behind the building will be a parking space for 250 cars.

In addition to its own membership the Society has made possible office space for the Hartford County Medical Association ever since the latter felt the need for such over twenty years ago. The County Association and the Woman's Auxiliary to the County Association have enjoyed the facilities of the Hunt Memorial in the past and the same policy will be continued in the new building. In view of the zoning regulations there will be no provision made for a telephone exchange.

Much credit is due the building committee comprising Thacher W. Worthen, chairman, Arthur B. Landry, vice-chairman, and Charles E. Jacobson, secretary. The architects are Westcott and Mapes and the builders, Gilbane Building Company of Providence, R. I.



## NEWS FROM WASHINGTON

### Dr. Klumpp New Chairman of Medical Task Force

Chauncey McCormick of Chicago, chairman of the Hoover Commission Medical Task Force, died early in September while on a vacation in Maine. Herbert Hoover has appointed a member of the Connecticut State Medical Society to fill Mr. McCormick's place, Theodore Klumpp, president of Winthrop-Stearns. The group has been studying the vast medical setup of the federal government with a view to proposing changes to the full commission. Dr. Klumpp's appointment further cements liaison with the Commission on Intergovernmental Relations, since he also is a member of that group's health advisory committee.

### Defense Department Expects Scholarship Bill Passage Next Year

Enactment of a military medical scholarship program "is anticipated during the next session of Congress," according to the annual report of Dr. Frank B. Berry, Assistant Secretary of Defense (health and medical). Under the plan students would be required to serve one year as physicians in the Armed Services for each scholarship year. Because obligated draft service also would be counted as scholarship pay-off time, a minimum of three years' active duty would be required of scholarship recipients.

Other points in the report: The Budget Bureau had numerous objections to the department's dependent care bill, but they were "resolved" before its introduction; a directive already has been prepared to implement the bill if it is passed. No argument is made for continuation of the Doctor Draft, due to expire next July 1; the report confirms that by last July 1 the ratio of physicians to troops was down to 3 per thousand, the maximum set by Secretary Wilson. Some difficulties and disappointments are anticipated in the induction of non-veteran physicians completing their internships, the group that will supply virtually all the military medical needs when the doctor draft ends; a poll by the Department shows that 50 per cent want

their deferments continued to allow time for additional training, but "in reality it will be possible to defer only about 10 per cent."

### Physician Shortage Forcing Navy to Use Civilians

Due to shortage of uniformed medical officers, Secretary of Navy has authorized utilization of civilian doctors. For time being at least they will be used only at Navy and Marine Corps industrial activities, such as navy yards, gun factories, etc. They may be hired on full-time Civil Service status, or as per diem consultants, or on fee-for-service basis. Army and Air Force have engaged civilian physicians for some time past but this marks Navy's first adoption of this expedient on a large scale.

Fee schedule: For regular station or sick call, five patients or fewer, \$15; for each patient in excess of five, \$3. For any one visit, compensation shall not exceed \$50, regardless of number of patients seen. If a repeat visit is necessary on same day, fee will not exceed \$5. For emergency surgery or other extraordinary services, payment will be compatible with prevailing rates of the area.

### VA's Prescription Policy "Clarified" by Dr. Boone

In some sections of country, druggists have been complaining that they've been getting too little prescription business in the "home town" pharmacy program. So Dr. Joel T. Boone, VA's chief medical director, has issued a "clarifying" memorandum for guidance of private physicians performing outpatient services for veterans on a fee basis. It alters no policy but, rather, states in general the circumstances under which prescriptions should be filled at a VA pharmacy and when they may be sent to a private drug store. Purpose of Boone directive was to placate the complainants; but net result may be a reduction in "home town" pharmacy volume, since memorandum stresses that VA facilities should be "utilized to the extent possible, consistent with the needs and best interests of patients and the government."

## AFL Set to Battle Anew for Health Legislation

Concluding its convention recently in Los Angeles, American Federation of Labor put emphatic reaffirmation to its health legislation platform. It again indorsed compulsory national health insurance as "the surest protection against the socialization of medicine in this country." But it is not a case of "all or nothing at all," said AFL, which recommended such interim measures as effective implementation of Hill-Burton hospital expansion; Federal mortgage loan insurance to promote construction of prepayment, group practice clinics; subsidies for professional education in health sciences; greater financial aid to state and local public health units, and improvement of facilities for care of mentally ill.

The labor convention rejected President Eisenhower's reinsurance plan. But on the speaker's platform HEW Under Secretary Nelson A. Rockefeller received a cordial reception when he reviewed the Administration's national health aims. Delegates like his conciliatory theme: "Somewhere between the extremes of 'do everything' and 'do nothing' is the middle way for which we must strive."

## Clinical Session Aimed at Alleviating Everyday Medical Problems

Easier solution of medical problems that the family doctor encounters is the general aim of the American Medical Association's clinical meeting in Miami, November 29 through December 2.

More than 100 physicians will present scientific papers or participate in panel discussions during the meeting, directed toward alleviating the everyday medical problems of the physician.

The meetings in Miami's Dinner Key Auditorium and the McAllister Hotel are expected to be attended by more than 3,000 physicians from throughout the nation.

Dr. Thomas G. Hull, secretary of the AMA's Council on Scientific Assembly, said "we have attempted to arrange a program of broad general interest rather than one showing merely the results of investigation or experimentation. While various specialties are represented at the meeting, such as medicine, surgery and obstetrics, the program is not for the specialist in these fields, but rather for the general practitioner who also must work in these areas."

The lecture programs will include subjects of broad interest in medicine, surgery, pediatrics, neuropsychiatry, obstetrics and gynecology.

Outstanding medical authorities also will participate in the scientific exhibit where more than 80 displays will be presented.

Leading surgeons and obstetricians will be available at the scientific exhibit for conferences with individual doctors on problems in fractures and deliveries. Doctors are invited to bring x-rays of fracture cases they wish to discuss. The obstetrical section will include manikin demonstrations of deliveries.

Another section of the meeting, the technical exhibit, will have more than 130 drug, medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations participating.

Motion pictures will be shown continuously during the meeting and a special filming will be presented on Tuesday evening, November 30, in the McAllister Hotel. This will be the premiere showing of two outstanding films—"Lung Cancer: The Problems of Early Diagnosis," sponsored by the American Cancer Society, and "Differential Diagnosis of the Arthritides" by Dr. William B. Rawls, New York.

Closed-circuit color television again will be shown to doctors attending the clinical session through the sponsorship of Smith, Kline and French Laboratories. Programs originating from Miami's Jackson Memorial Hospital will be brought directly into the lecture hall.

The House of Delegates, the policy-making body of the AMA, will hold its sessions in the McAllister Hotel.

## Dr. Mulholland Coming to New Haven

Dr. Henry B. Mulholland, assistant dean and professor of internal medicine at the University of Virginia Medical School, will address the New Haven Medical Association on Wednesday, November 17 at 8:45 P. M. in the Association auditorium at 364 Whitney Avenue. He will speak on diabetes and discuss the new Lente Insulin.

Dr. Mulholland is president of the American Diabetes Association and will be the guest of the Connecticut Diabetes Association. His visit here will inaugurate the annual Diabetes Detection Drive to be held during Diabetes Week, November 14-20.



## GOALS FOR MEDICAL EDUCATION

The goal of the American Medical Education Foundation's 1954 campaign is two million dollars.

The National Fund for Medical Education plans to raise eight million dollars for our medical schools from industry and other corporate groups.

Never before has medical education been so widely supported — and never before has the leadership of physicians been so vitally needed by our medical schools. If you haven't contributed to the 1954 campaign, you may obtain a contribution card by using the coupon on this page.

Medical Education  
Needs Your Help

H. M. Marvin, M.D., President  
Connecticut State Medical Society  
160 St. Ronan Street  
New Haven 11, Connecticut

Please send a contribution card and information concerning the American Medical Education Foundation.

Name .....

Office Address .....

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington  
*Chairman*  
Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford  
James C. Canniff, Torrington  
Morris A. Hankin, New Haven

Harry C. Knight, Middletown  
James H. Root, Jr., Waterbury  
Alfred J. Sette, Stamford

First Aid Charts In High Demand

The first aid charts published by the Society in cooperation with the Woman's Auxiliary have met with a high degree of public acceptance.

More than 5,000 copies were distributed at 15 country fair health exhibits and ten thousand copies were distributed at the Fairfield County Medical Association's exhibit at the Danbury Fair. Several hundred requests were received following one of the Society's recent television programs during which the chart was shown and a number of local health officers have requested copies for distribution in their communities. Several thousand copies also have been requested for distribution to industrial plants by the Department of Industrial Hygiene of the State Department of Health.

Five National TV Programs In 30 Days

October was TV month for medicine, with five national network programs bringing news of medical progress and dramatizations to millions of television viewers.

All of the programs were televised over the network of the National Broadcasting Company, starting with the story of Hippocrates on the Hallmark Hall of Fame, Sunday afternoon, October 10. The following evening the nationwide audience of "Medic," the three time monthly presentation of the Dow Chemical Company, witnessed another strong dramatization in this popular series. The series is endorsed by the Los Angeles County Medical Association and two more of its programs were presented on successive Monday evenings during October.

On Sunday afternoon, October 31, medical TV was again on the air with the first fall program in the March of Medicine series, sponsored by Smith, Kline and French Laboratories in cooperation with the American Medical Association. The program dramatically presented progress in research in the treatment of mental illness.

County Associations and Auxiliary Planning  
Radio Health Series

Health broadcasts from the studios of local radio stations are being considered by the public relations committees of two county medical associations in cooperation with local chapters of the Woman's Auxiliary.

In Litchfield County a series of transcribed programs furnished by the Bureau of Health Education of the American Medical Association is now being reviewed to select a suitable program. The series is being planned for one 15 minute broadcast each week for 13 weeks, at which time a new series will be aired. Mrs. Daniel P. Samson, Thomaston, is chairman of the Auxiliary radio committee, while the Litchfield County Medical Association is represented by Dr. James C. Canniff, Torrington, chairman of the Association's public relations committee.

A similar radio series is being considered by the Middlesex County Medical Association and a committee of the Woman's Auxiliary headed by Mrs. Willard E. Buckley, of Middletown.

Country Fair Project Completed

October 10 marked the termination of the 1954 country fair project sponsored by the Society's Committee on Rural Health and the Woman's Auxiliary, in cooperation with Connecticut Medical Service.

Exhibits were displayed at 15 fairs by committees of the local chapters of the Auxiliary from August 30 through October 10. This represented the largest number of fairs to be included in the project since it was inaugurated four years ago.

Thousands of copies of health publications, ranging from first-aid charts to pamphlets on emergency medical call plans, modern drugs, voluntary health insurance and how to select family physician were distributed to patrons of the fairs by committee members.



Leaders of the project in the various counties were: Mrs. John A. Bucciarelli, New Canaan, Fairfield County; Mrs. W. Holbrook Lowell, Jr., Wethersfield, Hartford County; Mrs. Daniel P. Samson, Thomaston, Litchfield County; Mrs. Willard E. Buckley, Middletown, Middlesex County; Mrs. Joseph J. Mahoney, Norwich and Mrs. Julian G. Ely, Lyme, New London County; Mrs. Barnett P. Freedman, New Haven, New Haven County; Mrs. Angelo J. Gulino, Plainfield, Windham County; and Mrs. Alfred Schiavetti, Stafford Springs, Tolland County.

## THE DOCTOR'S OFFICE

Robert T. Barry, M.D. announces the opening of an office for the practice of general surgery at 137 Jefferson Street, Hartford.

Lawrence S. Carlton, M.D. announces the opening of an office for the practice of general medicine at Dyer Avenue, Collinsville.

Joseph C. Cullina, M.D. announces the opening of an office for the practice of pediatrics at 1013 Farmington Avenue, West Hartford.

Joseph Fraknoi, M.D. announces the opening of an office for the practice of general surgery at 37 North Main Street, Meriden.

T. A. Munson, M.D. announces the opening of an office for the practice of psychiatry at 279 Farmington Avenue, Hartford.

Douglas J. Roberts, M.D., Ralph T. Ogden, M.D., Wendell C. Hall, M.D., C. Leonard Smith, M.D., William A. Goodrich, M.D. and John H. Woodruff, M.D. announce the opening of another office for the practice of general radiology at 1005-F Farmington Avenue Plaza, West Hartford.

Niel Russo, M.D. announces the opening of an office for the practice of general medicine and surgery at High Street, Thomaston.

William L. Saunders, M.D. announces the opening of an office for the practice of general medicine at 12 Mayflower Street, Elmwood.

Edward R. Smith, M.D. announces the removal of his office for the practice of surgery to 543 West Main Street, Meriden.

## LETTERS TO THE EDITOR

August 25, 1954

To the Editor:

In the July issue of the CONNECTICUT STATE MEDICAL JOURNAL, was an evocative article on words and their roots taken from early Greek and Latin.

The writer, the current President of the Association, suggests their study as a diversion and by-line in the nature of a collector's item. This point is well taken and serves as an inspiration to recount some periods of my homework on kindred subjects.

While history does not always repeat itself, historical situations do recur, and directly useful lessons can be learned from the past.

Going back to the Greeks for words and deeds, we find Hippocrates, the Father of Medicine, a beacon light showing that every illness has a natural cause, yet without the use of basic science he formulated sensible rules of diet and hygiene.

In that era was a dramatist Sophocles, who drew up a king's size Oedipus complex from a pack of fates and gave it such human understanding that it has survived the ages. It made considerable impression on Freud and even modern playwrights succumb to its tragic features and put it alongside the Shakespeare revivals.

A few centuries later Plutarch, another Greek, writing in Rome about their politics and night life, built the foundation for the current cinema "Julius Caesar." Shakespeare took over this framework and by adding here and there an ornate bit of frieze and facade, he left an imposing temple.

In the first act he had Casca observe the psychology of an unruly mob in the public square. They milled about the Dictator protesting his reluctance to accept the crown. To quote, "and still as he refused it, the rabble shouted and clapped their chopped hands and threw up their sweaty night caps, and uttered such a deal of stinking breath, that it almost choked Caesar . . . for he fell down at it, foamed at the mouth and was speechless."

A perfect trigger mechanism of excitement and smells to set off a convulsive seizure. The first aid care has not changed much. The licitor pried open

his mouth and pushed the sleeve of his toga therein. When the spasm subsided, they put him on a litter and carried him to his villa.

Flying over the dark centuries to an era of the mid 16th century, a galaxy of genius appeared on the horizon.

Andre Vesalius, teaching anatomy at Padua, left superb charts with a permanence in black and white for the medical libraries. In some of which, in a semi-circle of a rotunda, grave and bearded faces look down in the arena at a mould of reality.

The dissections are open and unerring on the marble slab. Nearby a timely artist catches the structures to scale, the symmetry of muscles, the shining capsule of a joint and the blood vessels without modern dyes. A tableau of homo sapiens in finalty is depicted for the new era.

The original wood cuts in the vaults at Munich during the last war were destroyed, yet the records endure.

Ambrose Pare, a surgeon to the King of France, fearful of branding his august majesty with a glowing iron point in case of a bleeding vessel, devised the ligature. He also contrived other surgical methods as the podalic version, but many of his views and cures lay dormant for over two hundred years.

With the stimulus of Padua in his mind, William Harvey returned to London with well grounded hopes to verify the circulation of the blood. Making his rounds on horseback, followed by his haut boy as a retriever, his dark furtive eyes searched the smelly alleys and by-ways for any stray flesh or fowl.

He tied and cut their arteries and veins, noting the pressure and flow before and after. One day he hung a sheep and drained the blood to determine that the total volume must of necessity be used over and over again. After a time he was convinced there was a continuous, rhythmic output and return. The missing link of the capillary bed was later revealed with the microscope.

It is interesting to speculate that a playwright and scholar may have discussed this symbolic medium over flagons of ale at the "Mermaid Tavern."

The ghost in Hamlet moans that the poison stilled in his ears "holds such ennity with blood of man, that swift as quicksilver it courses through the natural gates and alleys of the body."

Harvey was at the head of his subject in the year of Shakespeare's death.

There are many gaps and missing parts of the record of London during this era. Perhaps much of it was destroyed in the great fire of 1666, which luckily marked the end of heavy epidemics of the plague, and noted a record of the first transfusion of blood. The perfection of the latter is within recent memory. It all makes a desire to smell out old manuscripts and be slightly touched with collectors' mania.

There will always be a lesser group, however, who will avow that Shakespeare's work was a myth, or say "How do you know that Anne Hatheway beguiled a young artist in that thatched roof cottage?" Well, Ben Johnson set things down and he was there.

The tragedy of "Macbeth" written nearly a quarter of a century after early Stratford days depicts considerable psychosomatic medicine, more so in the leading characters than that expressed by the two doctors in the cast.

Early in the play we find apt quotations to represent these days of stolen cars and pay roll bandits. Macbeth planned with his henchman to do in Banquo, who appeared to stand in his way towards power. The first thug said in effect, Act I, Sc. 3, "I am one, chief, whom the vile blows and buffets of the world have so incensed that I am reckless what I do to spite the world." The second parolee said, "And I another so weary with disasters tugged with fortune that I would set my life on any chance to mend it or be rid of it." The deal went through as Banquo was rubbed out with the darkness.

After three centuries there is a difference in the outlook of violence. Now the situation is worse and more prevalent, but without choice of a whipping post. Modern thought has taken care of that, but appears to be in a dilemma for a substitute method of reform. A large scale study with long distant vision and plenty of hope seems desirable to effect protection.

There is considerable reward and satisfaction in brushing aside cobwebs of antiquity to note the struggle and fortitude of the pioneers to bring new constructive ideas into the open. For abstract imagery it may help to be in accord with the old lady who said she liked "Hamlet" because it contained so many quotations.

Then again we have the footnotes and substance between the lines, which are readily soluble in the matrix of ten billion cortical cells.

T. J. O'Donnell, M.D.





### Health Exhibits of the Fairfield County Medical Association Proves One of Most Popular Attractions at Danbury Fair

Dr. Howard A. Felding, Stamford, is shown in this picture inspecting the Fairfield County Medical Association's health exhibit prior to openings of the gates for another busy day at the Danbury Fair. Several physicians from a 21 member committee arrived later to help answer the inquiries of the large number of visitors.

The exhibit proved to be one of the most popular at the fair and was attended by thousands of the more than 153,000 persons who visited the nine day event, October 2-10. Approximately 18,000 first-aid charts and emergency call plan leaflets were distributed to patrons.

The exhibit was a project of the Association's Public Relations Committee, under the chairmanship of Dr. Alfred J. Sette, Stamford. The scientific section of the display was obtained from the Ameri-

can Medical Association's Bureau of Exhibits.

Members of the Woman's Auxiliary to the Association assisted in managing the exhibit through a committee headed by Mrs. John A. Bucciarelli, New Canaan.

Physicians who served on the Association's committee were: George Mandl, Bethel; M. David Deren, George K. Pratt, Bridgeport; Leonard A. Howard, Cos Cob; Roger P. Castro, Victor A. Machcinski, William A. Stinton, Henry N. Blansfield, Isadore L. Amos, Dean H. Edson, Frank M. Goldys, Robert C. Joy, Charles K. Hamilton, Serafino Genovese, Danbury; Frederick W. Finn, Greenwich; Francis B. Woodford, Edward J. Wagner, Ridgefield; D. Olan Meeker, Riverside; Howard A. Felding, Alfred J. Sette, Stamford; Harry A. Bradley, Jr., South Norwalk.



## FROM OUR EXCHANGES

Pomeranz and Kirschner (*N. Y. State Jour. Med.*, 54:13) sound a warning that physicians must be on their guard against sulfasuxidine sensitivity. Sulfathiazole, the active principle of the relatively insoluble sulfonamides, is the agent responsible for these reactions. They suggest the importance of obtaining a history of sulfonamide allergy prior to the administration of either sulfasuxidine or sulfathalidine. The six cases on which their study was based showed immediate reactions in three and delayed reactions in the other three cases. These cases developed high temperatures, skin rashes, and a blood count that was normal with a shift in the differential count, so that the polymorphonuclear leukocytes sometimes ranged to 91 per cent and the nonsegmented (band) forms up to 37 per cent. Symptoms were sometimes delayed as long as seven days.

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"The Modern Chemotherapy of Infectious Diseases; Implications and Significance" is a study of a similar nature (*Dis. of Chest*, XXVI:1). Feldman, the author, makes a plea against the indiscriminate use of medicinals, all of which have potential toxicity. The substantial value of modern therapeutic agents is recognized. However, there is a hazard attached to them all; and this is particularly true of agents having a broad antibacterial spectrum and in those situations where chemotherapy is continued for a prolonged period. Vigilance is a continuing responsibility if patients are to have reasonable assurance of their safety. The site of predilection for toxic effects include some of the most vital organs of the body, and that toxic impact in some instances may be violent and even catastrophic in nature.

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"Painless Myocardial Infarction; A Review of the Literature and Analysis of 220 Cases" calls attention to a cardiac situation too often overlooked (Roseman, *Ann. Int. Med.*, 41:1). "When infarction supervenes in a case with pre-existing signs and symptoms of heart failure, the picture is less distinctive. Pain is not a prominent symptom; it is either absent or quite overshadowed by dyspnea. A sudden exacerbation of signs of failure may be the

only evidence of cardiac infarction" (Parkinson and Bedford, 1928). In the author's series of 220 cases, 2.3 per cent had painless infarcts. Of these (10 cases) only five had reliable histories. The common symptom in painless myocardial infarction was dyspnea. The conclusion is that, while painless myocardial infarction does occur, its incidence is extremely low.

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The employment of patients with coronary artery disease must take into account the return to work (Kaufman and Becker, *Ann. Int. Med.* 41:1). The principal risks that the employer takes are: (1) possible danger to property in the event of a sudden cardiac emergency; (2) those related to compensation liability and larger insurance premiums, and (3) possible excessive absenteeism. Some of these obstacles to employment may be avoided by job selection. However, there should be a revision of the legal aspects covering the entire subject, looking toward a mutual understanding among physicians, attorneys, legislators, labor and management. Uniform compensation laws should be enacted and impartial medical opinion should be used in the adjustment of claims.

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"Lung Neoplasms from the Endoscopist's Standpoint" points up some interesting conclusions as they are made by Gregg (*S. Dak. Jour. Med. & Pharm.*, VLL:7). The advent of the new antibiotics has delayed the diagnosis of lung cancer from two to six months. The patient has been treated for "pneumonitis, atypical pneumonia, and virus pneumonia" and the like. If a chest lesion is not resolving in about three weeks in a person over 35 years of age and especially a male it should be investigated thoroughly. Symptoms, physical findings and x-rays are often minimal in early lung neoplasms. Bronchogenic carcinoma is apparently increasing. The diagnosis of lung cancer is improving due to refinements in x-ray, bronchoscopy and cytology techniques. "Placer mining" bronchial aspiration has increased the number of exfoliated cells aspirated from a suspicious lung segment. Spun-down specimens and paraffin blocks for pathological sections have resulted in better specimens and a decrease in man hours in



making cytology specimens. "Placer mining" aspiration does result in false-positive findings, but not too often. Periodic x-ray of the chest results in an early finding of cancer of the lung as compared with a dependance on clinical findings to start the investigation. Lung cancer can be cured only by a prompt, early diagnosis and adequate surgical excision of the tumor along with the neighboring lymphatic system.

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"The Probable Systemic Nature of Mikulicz's Disease and Its Relation to Sjögren's Syndrome" is discussed by Morgan in *New England Journal of Medicine* (251:1). Mikulicz disease is described as a benign, asymptomatic, symmetrical enlargement of the lacrimal and salivary glands. There is an atrophy of the acinar parenchyma and a diffuse replacement by lymphoid tissue. Sjögren's syndrome, or the sicca syndrome, consists of the decrease or absence of lacrimation associated with a dry, filamentary keratitis and conjunctivitis. Dr. Morgan, from pathological studies, believes that the two conditions are identical. A re-examination of cases of so-called Mikulicz Disease revealed that a significant number had components of Sjögren's syndrome. The high incidence of rheumatoid arthritis in Sjögren's syndrome suggests that the pathological process in the salivary and lacrimal glands is similar and of systemic origin.

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Weil studied clinically, pharmacologically and by EEG 42 cases of migraine headaches ("Dysrhythmic Headache," *Ohio State Med. Jour.*, 50:7). Ten patients (24 per cent) showed abnormal to grossly abnormal electroencephalograms as well as neurological-psychiatric and pharmacological responses not usually observed in "ordinary" migraine. His conclusion was that this study did not justify the term "dysrhythmic migraine" as applied to the findings in his 42 cases.

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Acute pancreatitis is, according to McDonald and Freeman, one of the commonest causes of severe pain in the upper abdominal region and frequently "the least recognized" (*Jour. Med. Assoc. Georgia*, 43:7). The attending staff and the house officers should become pancreatitis conscious by obtaining early blood amylase determinations. Acute pancreatitis may regress or lead to an abscess, cyst and

calcification of the pancreas. Duct obstruction is the main factor in etiology, whether due to spasm, metaplasia of duct epithelium, or stone. The Somogyi method of blood amylase (diastase) determination is quick, accurate and technically easy to perform. Nonoperative or medical therapy is the treatment of choice unless complications such as an abscess, cyst, or calcification occur.

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The Needle Biopsy of the Liver can be informative according to Ober. (*Jour. Maine Med. Assoc.*, 45:7, pp. 183-186.) It is a reasonable procedure (based on 51 cases) provided the hospital is equipped to give emergency transfusion in case of hemorrhage, and provided a member or two of the clinical staff are sufficiently interested to familiarize themselves with the method and perform all such biopsies. It can be expected that such biopsies will aid materially in the diagnosis and management of hepatic disease as well as more generalized diseases that involve the liver.

### New Cause of Heart Damage Discovered

Discovery of a powerful heart poison in a chemical from the streptococcus germ was announced by Aaron Kellner and Theodore Robertson of New York at the World Congress of Cardiology which took place in Washington, D. C., September 12-17. It is believed that this substance, a protein-digesting enzyme called streptococcal proteinase that was isolated in crystalline form in 1950 by S. D. Elliott of the Rockefeller Institute, may be the cause of heart damage following rheumatic fever attacks.

Kellner and Robertson injected the enzyme into the veins of rabbits, mice, guinea pigs, and cats. It caused striking damage to the muscles and valves of the animals' hearts, with an inflammatory reaction. With only a few exceptions, the enzyme's destructive action was confined to the heart. When the enzyme was added to the fluid in which an isolated rat heart was being kept alive and beating, contractions soon decreased in strength and frequency, and heart failure occurred within a few minutes.

Rheumatic fever attacks 30,000 Americans yearly, most of them between the ages of five and fifteen. It is responsible for an estimated 1,000,000 cases of rheumatic heart disease in the United States.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. Newell W. Giles, Darien

*President-Elect*, Mrs. Norman J. Barker, Collinsville

*First Vice-President*, Mrs. J. ALFRED WILSON, Meriden

*Second Vice-President*, Mrs. Frank L. Polito, Torrington

*Recording Secretary*, Mrs. Charles Culotta, Hamden

*Corresponding Secretary*, Mrs. C. Murray Gratz, Cos Cob

*Treasurer*, Mrs. Joseph Woodward, New London

The eleventh annual Conference of State Presidents, Presidents-Elect and National Committee Chairmen will be held in Chicago, November 16-18. "Leadership in Community Health," the theme of the national president for the year 1954-55, will be the predominant element of the presentations, with the national chairmen serving as moderators and the state presidents (or presidents-elect) as participants. The guest speaker for the Tuesday luncheon will be Dr. Walter Martin, president of the American Medical Association. On Wednesday the luncheon speakers will be public relations representatives from three outstanding industrial firms in Chicago.

### Semi-Annual Meeting

The State Auxiliary's semi-annual luncheon meeting will be held at the Waverly Inn, Cheshire on Tuesday, November 9. H. M. Marvin, president of the Connecticut State Medical Society, who is a cardiologist, will be the guest speaker.

### Nurse Recruitment

At the October meeting of the State Auxiliary board, Mrs. Emerson Stone reported on Nurse Recruitment. The committee has decided it can best help by "fitting in, rather than by adopting an arbitrary uniform course of action; by using woman's intuition; by not being necessarily consistent in all communities. Cities and industrial areas of our State are suffering severe shortage of nursing service; smaller town and rural areas have abundant nursing personnel, both graduate and student. This paradox, that the most nurses are where they are least needed, accounts for the decision that our policy must be kept flexible. In all cases we must give encouragement. Girls who feel drawn to nursing, though they live in a section abundantly supplied, should be helped to find entrance to a training school elsewhere.

"Future Nurse Clubs are another of our responsibilities. Whereas the custom has been to enroll

members of junior and senior classes, our experience is that sophomore-juniors, with seniors ex officio, make a more efficient group. Thus the busy seniors are relieved and the sophomores have a chance to learn about educational requirements for training and to adapt their course of study during their last two years at high school to that end."

### County News

#### HARTFORD

At the September board meeting, Mrs. N. Marinaro, membership chairman, reported that there are 421 paid members, an increase of 40 since April.

In early September the new Directory and Program booklet, which this year also contains a copy of the Constitution and By-Laws, was mailed, together with a news letter, to all members.

The semi-annual meeting was held at the Hotel Statler on October 26. Dr. Dorothy Haustmann, associate professor of preventive medicine, Yale School of Medicine, spoke on "Progress in the Polio Field."

#### FAIRFIELD

On September 28 a Fashion Show and Tea was held at Bloomingdale's in Stamford for the benefit of our Nurses Scholarship Fund. As of October, receipts were \$107.

Mrs. Vincent Gorman of Trumbull held a buffet supper in her home on October 9 for new doctors and their wives in and around Bridgeport. It is hoped others will be held in Fairfield County to further friendly relations and promote mutual understanding among physicians' families.

The October 19 semi-annual meeting, held at the Yankee Drover Inn, Newtown, had as its guest speaker Mr. Merle Mudd, program director for the Connecticut State Department of Mental Health. His subject was "Mental Health in the Community."

#### LITCHFIELD

Program plans were discussed at the first fall board



meeting and it was decided to emphasize mental health in our work this year. Our mental health chairman will work on a survey of the existing psychiatric services in our county with particular attention paid to an evaluation of their adequacy.

The Auxiliary is anxious to have a closer association with our County Medical Association and would like to do more things under their advice and direction. Dr. James Canniff of Torrington has been appointed our advisor and Mrs. Clifford Conklin and Mrs. Daniel Samson met with him and Dr. William Dobbs, State chairman of public relations, and Mr. James Burch. With their advice we are arranging a series of radio programs on health to be heard over our county station, WLCR.

#### MIDDLESEX

The semi-annual meeting was held on October 14 at Restland Farms in Norford. The Auxiliary was guest of the County Medical Association at dinner. Guest speaker for the evening was Dr. D. Olan Meeker who discussed "Current Medical Legislation."

Plans are being made for use of the AMA transcriptions series entitled "Hi-Forum" to be heard over Station WCNX, Middletown, beginning in January.

#### NEW HAVEN

Mrs. Harry Conte, chairman of the ways and means committee, announces that her committee is sponsoring a Fair and Bridge to be held November from 1:00-5:00 P. M. at the New Haven Medical Association Library. Hand painted articles, aprons, food and white elephant articles will be for sale. A hand writing analyst will be present.

Mrs. Barnett Freedman, public relations chairman, was responsible for the booth sponsored by the Auxiliary at the North Haven Fair, September 11-14.

#### NEW LONDON

A Student Nurse Scholarship and Welfare Fund bridge and cake sale were held at Lighthouse Inn in October.

Mrs. Henry Archambault is contacting the county schools to see if a Home Nursing or First Aid course could be incorporated in their curriculum. This is in connection with Civil Defense.

Two Health Exhibits were set up at the Hamburg County Fair August 20, and Norwichtown Grange Fair September 17 and 18.

#### WINDHAM

In cooperation with the State Medical Society, a Health Exhibit was displayed at the Woodstock Fair on September 4, 5 and 6.

On September 16 a board meeting and luncheon was held at the home of Mrs. Angelo Gulino in Plainfield. It was recommended that we increase our contribution to the AMEF from \$25 to \$50.

### Attention, Fathers!

Baseball wives have a simple way, it seems, for teaching their husbands how to swaddle a new baby, according to *The New York Times*. They lay the breechcloth out in the form of a baseball diamond. "Now," they tell the player, "you take the batter's position at the low end of the cloth; bring center field down to home plate. You put the baby in the pitcher's box. You bring first base, third base and home plate together. If the game is rained out, you start all over."

### New Harvard Medical School Plan

George Packer Berry, dean of medicine at Harvard, has revealed that a five year grant of \$275,000 has been received from the Rockefeller Foundation to provide medical students with the firsthand experience of observing sickness in American families at home. The plan will integrate the teaching of comprehensive medical care into the medical school curriculum.

In this new phase of medical education, Harvard's medical students will be assigned to families living in the vicinity of, and now receiving medical care from, the Massachusetts General Hospital and related community agencies.

Teaching will be directed toward normal child growth and development, early recognition and evolution of chronic diseases, hereditary and environmental influences on health and illness, and methods of disease prevention.

### Dr. Hamilton Re-elected Regent

T. Stewart Hamilton, director of Hartford Hospital, was re-elected regent of the American College of Administrators for a term of three years at a recent meeting of the college. Dr. Hamilton will represent the New England region in this famous society which now has over 2,500 affiliates.

## SPECIAL NOTICES

### CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

November 4

"The Suction Socket in Lower Extremity Prosthesis"

John Trapuzzano, M.D.

November 18

"Visual Survey of Vascular Diseases"

Paul M. Sherwood, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room. All interested physicians are cordially invited to attend.

### AMERICAN COLLEGE OF SURGEONS

#### Meeting of State and Provincial Counseling Committees, Credentials Committees, Committees on Applicants and Judiciary Committees

A conference for discussion of the work of these committees will be held at 10:00 A. M. to 12:00 noon, Wednesday, November 17, 1954, Belvedere Room, Traymore Hotel, Atlantic City, N. J.

Evarts A. Graham, M.D., F.A.C.S., St. Louis; chairman, Board of Regents, presiding.

#### Judiciary Committees and Their Importance

Paul R. Hawley, M.D., F.A.C.P., Chicago; the director

#### The Function of Counseling Committees

H. Prather Saunders, M.D., F.A.C.S., Chicago; associate director

#### New Requirements for Fellowship

George W. Stephenson, M.D., F.A.C.S., Chicago; assistant director.

#### Discussion

Each member of the Counseling Committees, Judiciary Committees, Committees on Applicants and Credentials Committees is urged to attend so that he may hear a presentation of the problems with which these committees are frequently confronted and so that he may ask questions or offer suggestions concerning the successful conduct of the work of the committees.

#### Annual Meeting, Fellows of the College

3:45-6:00 P. M., Thursday, November 18, 1954, The Ballroom, Convention Hall, Atlantic City, N. J.

### THE SIXTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

To be held at The Palmer House, Chicago, Illinois December 13-17, 1954. Under the co-sponsorship of The

American Committee on Maternal Welfare and The American Academy of Obstetrics and Gynecology.

Room reservation request should be made to 116 South Michigan Avenue, Chicago 3, Illinois.

### AMEF FOURTH ANNUAL MEETING TO BE HELD JANUARY 23, 1955

The Fourth Annual Meeting of American Medical Education Foundation State chairmen will be held at the Sheraton Hotel in Chicago on Sunday, January 23, 1955. Specific details regarding the proposed program and reservation forms for accommodations at the Sheraton Hotel will be distributed with the November Bulletin to AMEF State chairmen and regional auxiliary chairmen.

### MIDDLESEX MEMORIAL HOSPITAL PROGRAM

The following is the Medical Education Program at present in effect at the Middlesex Memorial Hospital in Middletown.

All physicians are invited to attend and take part in it and all interns are required to do so.

Daily—Ward rounds in all services.

Monday—Clinical-pathological conference or chest conference on alternate Mondays from 12:00-1:00.

Tuesday—Heart clinic on second and fourth Tuesdays at 9:30.

Wednesday—Tumor clinic on first Wednesday at 9:30. Psychosomatic rounds on last two Wednesdays from 9:30-11:00. Prenatal clinic on first and third Wednesdays at 1:00.

Friday—Grand rounds every Friday at noon. Guest speaker giving case presentation and lecture on last Friday from 11:00-1:00.

There are teaching conferences for the interns in electrocardiography and x-ray interpretation as well as in all clinical fields.

### EYE, EAR, NOSE AND THROAT SECTION

All physicians limiting their practice to Eye, Ear, Nose and Throat are cordially invited to become members of the Eye, Ear, Nose and Throat section of the Connecticut State Medical Society. Any physician desiring to be put on the mailing list will kindly communicate with Dr. Max Alpert, 881 Lafayette Street, Bridgeport, Connecticut.

### CLINICAL FELLOWSHIPS IN CLINICAL MEDICINE AND REHABILITATION

The National Foundation for Infantile Paralysis announces the availability of a limited number of clinical fellowships in the fields of physical medicine and rehabilitation. These are offered to physicians who wish to become eligible for



certification by the American Board of Physical Medicine and Rehabilitation.

These fellowships are awarded as a part of the National Foundation's program of professional education for which more than \$19,000,000 in March of Dimes funds have been appropriated since 1938.

It is the responsibility of each applicant to arrange his own program of study, which must be planned to meet the requirements of the American Board of Physical Medicine and Rehabilitation. Each recipient of a fellowship must agree to practice as a specialist in physical medicine and rehabilitation in the United States or its territories for at least two years following the completion of his fellowship.

Applicants for fellowships must be physicians licensed to practice medicine in one or more States who have graduated from an approved school of medicine, have completed an internship of not less than one year in an approved hospital, are citizens of the United States (or applicants for citizenship), and are in sound health. Ordinarily applications will not be accepted from candidates over 40 years of age.

Selection of candidates is made on a competitive basis by the National Foundation's Clinical Fellowship Committee. Appointments are made for periods of one, two or three years of clinical study, depending upon the length of time required by the applicant to prepare himself for certification by the American Board of Physical Medicine and Rehabilitation.

Fellows receive stipends ranging from \$300 to \$400 per month depending upon marital status and the number of dependents.

Applications may be submitted at any time during the year. However, to be considered in February, applications must be received by December 1; to be considered in May, applications must be received by March 1; to be reviewed in November, applications must be received by September 1.

For further information and application blanks address: The National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

### EUROPEAN TOUR

The American Medical Association, in conjunction with United Air Lines, has arranged an attractive post-convention tour to Europe. Seven countries will be visited: France, England, Italy, Holland, Belgium, Germany, and Switzerland. Physicians and their wives can go to Europe following the annual AMA Convention in Atlantic City, June 6-10.

With the AMA meeting being held in Atlantic City, physicians and their wives are offered an unusual opportunity to combine a trip to the East Coast with a visit to these interesting European countries. Similar trips have been sponsored by the California Medical Association, the World Medical Association, and other groups when their meetings have been held on the coast.

The European medical tour party will leave New York International Airport aboard special deluxe chartered airliners on Sunday, June 12. They will arrive in Paris late Monday morning, June 13.

All through the tour the party will stay at luxurious hotels in the many cities that will be visited. Motor coaches will provide interesting side tours to historic and scientific points.

Arrangements are being made for medical meetings in Paris, Rome, Lucerne, and London. Leading European scientists will lecture on topics of current interest to all physicians.

The return trip will be on Saturday, July 9, arriving in New York on the afternoon of July 10. Complete information and reservation blanks can be obtained by writing AMA Post-Convention Tour, c/o United Air Lines, 5959 South Cicero Avenue, Chicago 38, Illinois.

### American College of Radiology Contributes

Mr. William C. Stronach, executive secretary of the American College of Radiology, recently forwarded a check in the amount of \$2,000 representing a gift to the American Medical Education Foundation from the ACR. Since the inception of the Foundation in 1951, the American College of Radiology has supported the AMEF program and has received two Awards of Merit for outstanding contributions.

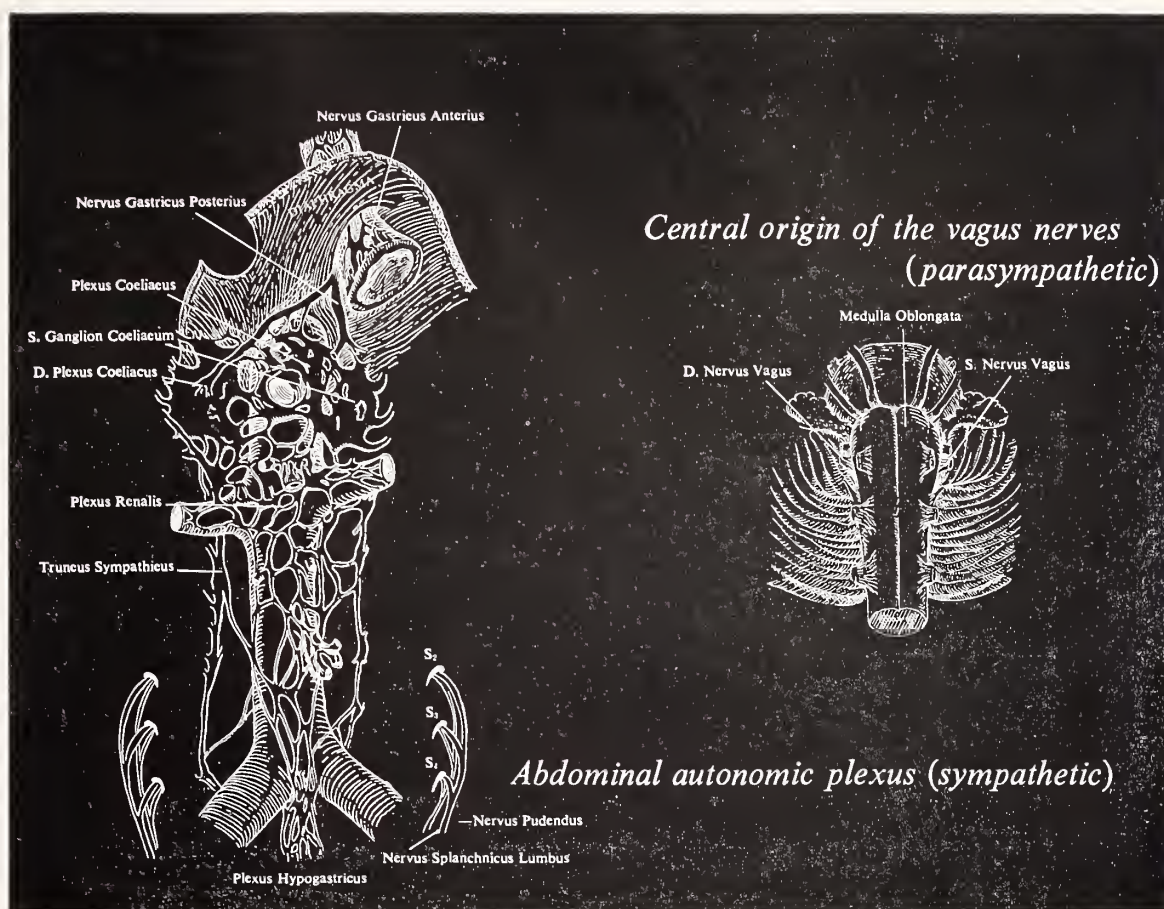
Although it was expected that contributions would pass the one million dollar mark in September, by October 1, the Foundation had received \$995,000 from 14,800 donors.

### John W. Hedback Joins AMEF Staff

Mr. John W. Hedback recently joined the staff of the American Medical Education Foundation in the capacity of associate executive secretary. Through many years of hospital public and community relations work, Mr. Hedback has gained valuable experience which will assist him in the development of State and local committees. The son of a physician, the late Axel E. Hedback, M.D. of Minneapolis, he has a keen interest in the problems of medical education.

### Geiger Counter For Stomach

J. Lenihan, leader of a research team in the department of surgery at Glasgow University that is investigating the causes of peptic ulcer, has devised a Geiger counter which is small enough to attach to a gastroscope. Development of this apparatus makes it possible to interpret exactly what is going on in the stomach after use of radioactive isotopes.



## Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthine®

"The need<sup>1</sup> for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

Banthine<sup>2</sup> "has dual effectiveness; it inhibits acetylcholine liberated at the post-ganglionic parasympathetic nerve endings and it blocks acetylcholine transmission through autonomic ganglia."

It has been shown<sup>1</sup> to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six

hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle Research in the Service of Medicine.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.



## NEWS

### *from County Associations*

#### Fairfield

The Bridgeport Medical Association at the regular monthly meeting held on October 5 in the auditorium of St. Vincent's Hospital was addressed by Attorney Herbert L. Cohen of Bridgeport on the subject, "The Doctor and His Income Tax." The meeting was well attended and was very informative. This talk was arranged by a committee of the association under the chairmanship of Joseph M. Adzima and consisting of Daniel P. Griffin and Anthony L. Camarda. The committee has planned four talks during the year on nonmedical subjects to stimulate attendance at monthly meetings of the association.

J. Grady Booe is convalescing successfully from his recent serious illness at his home on Long Hill Avenue in Shelton. Dr. Booe is attending proctologist at Bridgeport Hospital and president of The New England Proctologic Society.

The semi-annual meeting of the Fairfield County Medical Association was held at the Ridgewood Country Club in Danbury on October 6. Many of the members who attended the business meeting spent the afternoon at the Danbury Fair where an exhibit was fostered by the Association and the Association's booth was manned by members of the Association and the Woman's Auxiliary to the County Medical Association. Forty members played golf in the afternoon at the beautiful Ridgewood Country Club. The business meeting was called by the president, Russell A. Keddy, at five o'clock. The president of the Connecticut State Society, H. M. Marvin; the executive secretary of the Connecticut State Medical Society, Creighton Barker; the chairman of the Council of the State Society, Thomas J. Danaher; the general manager of Connecticut Medical Service, William H. Horton; the director of Public Relations of the State society, Mr. James G. Burch were guests and each spoke briefly. Dr. Barker introduced Mrs. Lindquist and Mrs. Duffy members of his staff at the State Society office building. Christopher E. Dwyer of Waterbury attended as the delegate from New Haven County Medical Association and brought greetings. The executive secretary of the Fairfield County Medical Association, Mr. Arnold P. Olson, was introduced and spoke

briefly, introducing Miss Morgan of his staff. C. Louis Fincke, chairman of the Board of Trustees, reported for that body and John P. Gens, alternate Councilor, gave the report of the Councilor. Alfred J. Sette, chairman of the Public Relations Committee, gave a detailed report of the accomplishments of the committee and outlined plans for the future of the committee and the association in the important public relations field. The meeting voted to raise the dues of the association for the year 1955. Thirty-four new members were added to the roster of the association. One hundred members and guests were present at the dinner in the evening at which the speaker was Rex Todhunter Stout, the creator of Nero Wolfe the sleuth of mystery stories, and Mr. Stout talked on some of the aspects of mystery writing of especial interest to physicians.

The Bridgeport Chapter of the Academy of General Practice will sponsor a series of lectures on "Industrial Medicine" beginning November 12. The lectures will be given every two weeks at Bridgeport Hospital and will be completed in March, the entire course consisting of eight lectures by prominent physicians in the field of industrial medicine. Physicians interested in participating in this course may contact the secretary of the Bridgeport Chapter, Edwin F. Trautman of Trumbull. The chapter will complete a course on "Office Gynecology" on October 22.

Preparations are progressing for the Annual Meeting of the Connecticut State Medical Society to be held at the Stratford High School in Stratford on April 26, 27 and 28, 1955. The Annual Dinner of the Society will be held at the Stratfield Hotel on April 27.

William Kaufman of Bridgeport presided at the recent meeting of the Academy of Psychosomatic Medicine held in New York City. His presidential address was entitled "The Physician's Role in the Preparation for Surgery."

#### Hartford

Dr. Richard Ford, medical examiner of Suffolk County, and acting head of the Department of Legal Medicine, Harvard Medical School, spoke to Hartford County Medical Association members at the Manchester Country Club on October 26. His talk: "Problems of the Pathology of Injury." Dr. Ford appeared before Connecticut physicians two years ago when he lectured at the Connecticut State Medical Society's annual meeting in Hartford. His demonstration and lecture covered his experiences as





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a medical examiner and were called "A Physician Looks at Murder."

Highlights of a recent physician study were: Nonsurgical specialists collected an average rate of 85 per cent of their accounts for 1953. The family physician collected an average of 81.8 per cent of their accounts, surgeons collected 83.9 per cent of their accounts and "other" specialists (radiologists, pathologists, anesthesiologists, etc.) collected 86 per cent of their accounts.

In the matter of giving itemized bills, 73 per cent of all nonsurgical specialists gave itemized bills to their patients. Seventy-seven per cent of all family doctors gave itemized bills. Better than 80 per cent of the surgeons gave itemized bills, and 78 per cent of "other" specialists gave itemized bills to their patients.

Surgeons led all classes in teaching—80 per cent taught. Nonsurgical physicians were next with an average of 76 per cent of their group teaching interns, nurses or medical groups. Sixty-five per cent of "other" specialists taught and 15 per cent of all family physicians indicated that they instructed some nurses, interns or medical groups.

As far as carrying an optimal load of patients, no classification averaged the maximum (the highest average was 85 per cent) though individuals within each group often ranged far above the optimal load.

Preparations are now being made by the executive office to offer an accounting bookkeeping service to Hartford County Medical Association members sometime this winter. This service, in its skeleton form now, will set up a simplified accounting system for each physician member who subscribes. Once each month simple cash receipts and charge notations will be collected and bills sent out to patients from these records.

The service will follow up patients who lag on payments, reminding them through a series of notes—all on the physicians' stationery—that payment is overdue. Then if necessary, Hartford County Medical Association will step in with a carefully worded letter requesting prompt payment or some personal appearance.

If after a certain number of months the patient does not respond, the executive office will recommend that the account be turned over a collection agency or an attorney.

As members subscribe, a file for bed debt "repeaters" and credit records will be maintained. All records will be completely confidential—different clerks will work on different portions of the doc-

tors' record so that no one has any complete grasp on the individual accounts or the volume of patients.

Off to Brazil: Stevens J. Martin, head of St. Francis Hospital's anesthesia department, left with his wife recently to address the second annual meeting of the Pan American Congress of Anesthesiologists at Sao Paulo, Brazil.

Bliss B. Clark and John C. White of New Britain and Benjamin V. White and Ettore F. Carniglia of Hartford presided at some of the sessions of the recent Clinical Congress in New Haven in September.

In charge of arrangements for the Northeast Regional Conference of the American College of Physicians held in Hartford in October was John C. Leonard, assistant medical director of Hartford Hospital.

First annual awards of the research fund of the Women's Auxiliary of the New Britain General Hospital were granted to William T. Livingstone for a report on a rare type of cancer, to Howard Levine to review dissection of the aorta with emphasis on diagnostic features, to Paul D. Rosahn for study and report on fibroelastosis and Samuel Wolfson to review causes and management of arrest of the heart.

The Connecticut Veterans Administration Medical Society heard Alex M. Burgess, M.D. of Providence, R. I. at their annual dinner meeting held at the Hotel Statler on October 21.


Lt. Col. Ralph M. Lechause of Manchester recently received the Army Bronze Star Medal during ceremonies in Tokyo for his work as Air Force base surgeon in Korea.

Benjamin L. Slavin and Walter A. Schloss collaborated on an article for the *Journal of Urology* entitled "Papillary Adenocarcinoma of the Kidney with Aortography Resembling Huge Renal Cyst."

In that issue, Philip M. Cornwell was the author of a paper on "Seminal Tract Calculi."

## Litchfield

The 190th semi-annual meeting of the Litchfield County Medical Association was held on October 5 at the Torrington Country Club. The meeting was preceded by a social hour and a dinner. Michael Giobbe, chairman of the Nonoccupational Health-Accident Insurance Committee reported that his committee had been able to handle the comparatively few cases referred to it quite satisfactorily, and that only two cases had come to its attention since the last meeting. He reported that he talked



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with industrial executives who reported that from their standpoint the plan was working out very satisfactorily.

Following the business meeting, the speaker of the evening, Henry P. Staats, of Litchfield, was introduced by Dr. Turkington. Mr. Staats showed a colored movie entitled, "Africa Safari." These pictures were taken by Mr. Staats while on a safari through Tanganyika, Kenya, and Uganda, in southern Africa, during the months of January and February of this year. Mr. Staats travelled by truck and car over about 3,000 miles, taking movies of the wild animals found in several reservations in this territory. Most of the pictures were taken with the aid of a telephoto lens and brought these huge beasts—elephants, lions, rhinoceros, hippopotamus, as well as various types of antelope and other animals—so close that many members of the audience looked about for the nearest exit in case one of these beasts should leap down from the screen.

### Middlesex

Carl C. Chase attended the annual meeting of The American Academy of Ophthalmology and Otolaryngology at New York the latter part of September.

### New Haven

Leonard C. Whiting, assistant clinical professor of ophthalmology, Yale University School of Medicine, died on September 25 at Grace-New Haven Community Hospital. Dr. Whiting was consultant in ophthalmology to a number of hospitals, was nationally prominent in Masonry, and was a major in the Connecticut State Guard during the World War II.

### New London

The semi-annual meeting of the New London County Medical Association was held on October 7 at Uncas-on-Thames. The business meeting was followed by dinner and a scientific session. The speaker was Arthur Thibodeau, professor of orthopedics at Tufts Medical School and visiting orthopedist at the New England Center Hospital, Boston. His subject was "Low Back Pain with Evaluation of the Present Status of ACTH and Cortisone in Orthopedics."

Thomas Soltz is presently recovering from a prostatectomy in Grace-New Haven Hospital.

Clemens Elias Prokesch has announced the opening of his office at 58 Huntington Street for the practice of internal medicine.

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The doctors of New London County at the annual meeting agreed to give their utmost support and cooperation to the Cornell University research committee for auto crash injuries which will be conducted for the next six months through the Groton Barracks of the State Police Department.

## NEW BOOKS IN REVIEW

*AFTER THE DOCTOR LEAVES.* By Marguerite Clark, Foreword by Howard A. Rusk, M.D. New York: Crown Publishers, Inc. 310 pp. \$3.75.

Reviewed by Ira V. Hiscock

The aim for this book is a practical guide to approved postmedical care and treatment of chronic diseases for the patient and his family after the doctor leaves. Twelve of the important medical classes of diseases are considered, with suggestions to supplement the advice of the doctor for the better understanding of the patient and the family at home. The author keeps her eyes and her alert mind on the target throughout, and as stated by Howard Rusk in a foreword for orientation and emphasis, "has done a real service for both patients and physicians." This is not surprising to those who follow Mrs. Clark as medical editor in *Newsweek* where she presents complex scientific observations in a simple and understandable manner.

That few of us are perfectly healthy, that we need to know how to live with our "civilized" diseases besides knowing the causes and symptoms, are among the concepts; while calling attention to changes following advances in medical science including increases in chronic ailments among old and young (afflicting one in six people in the United States). Special attention is given to heart disease, high blood pressure, rheumatism and arthritis, "When you have had cancer surgery," diabetes, ulcers, tuberculosis, the allergies, diseases of the central nervous system, disorders of the musculoskeletal system, mental and emotion troubles, and "When you grow old."

If this reviewer is a fair sample of readers, ability to attract attention is noteworthy, as for example, while reading in the introduction that sooner or later most of us experience a chronic illness and must find a way to adjust to impaired health. "This may be nothing more severe than hay fever or nearsightedness"—or both! and later, on growing old,—“But who can say that every man awakens on his

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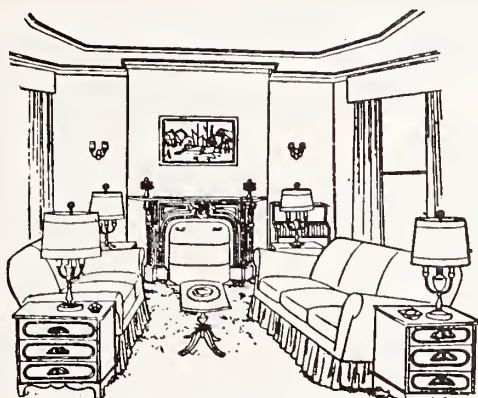
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sixty-fifth birthday with marked changes in physical or mental equipment that were not noticeable twenty-four hours before?" For "You may be as old as your birth certificate, or as old as you feel, or as old as the condition of your heart, kidneys, or other vital organs." We are reminded finally that whether the time on earth is short or long, the elderly man or woman feels the challenge to spend it courageously and in tranquility. But it is unfair to lift sentences from context, and many will enjoy passages in this book and will derive benefit from having it for reference purposes. In its preparation, acknowledgment is given for the cooperation of physicians, specialist, rehabilitation and geriatric authorities and others.

*THE INITIAL INTERVIEW IN PSYCHIATRIC PRACTICE.* Merton Gill, M.D., Richard Newman, M.D., and Frederick C. Redlich, M.D. New York: International Universities Press. Pp. 415. \$6.00. With phonographic records \$4.60 extra.

Reviewed by FRANCIS J. BRACELAND

In a trail blazing presentation which may well mark the beginning of a teaching method which will be widely used in psychiatry, the authors present a volume upon the extremely important "Initial Interview" in psychiatry. They illustrate their own techniques and procedures with phonographic records. The plan is to read the book and absorb the ideas, and then play the records and hear actual initial interviews in progress.

The authors' study of the initial interview left them dissatisfied with what they learned about both the theory and practice of the techniques employed. They believe a new technique is emerging and they propose by this offering to make a contribution to the systematic presentation of this technique. They hold that the initial interview has three main aims. The first is to establish rapport between the doctor and patient, the second is to appraise the patient's psychological status and the third aim is reinforcement of the patient's desire to continue treatment and plan its direction with him.

It should be noted that the authors are working in a narrow field. They exclude organic problems from their considerations and are only considering a patient's suitability for psychotherapy. Admittedly they are bypassing the whole field of somatic psychiatric therapies.

After a discussion of the early formulations the authors proceed to discuss the various modifications and improvements in interviewing which have been made and then consider the influence which psychoanalytic research has brought to bear on the subject. They then discuss the various types of interviews and set forth their own approach, detailing the various steps in the process. There is also a discussion of recording and its influence upon both patient and therapist.

Part II of the book is concerned with the interviews proper. The pertinent statements of the patient and therapist are placed on the left hand page and numbered; the editors comments are similarly numbered on the right hand pages. The first and third interviews are by experienced clinicians and the second is by a student. The differences are obvious and are forcefully brought out in the records.

The authors are forthright and frank and do not hesitate to criticize themselves. All in all, they have an excellent idea and it is well carried out and illustrated. One naturally will not agree with everything said, but both book and records will bear careful scrutiny by all psychiatric teaching institutions for they have a great deal to offer.

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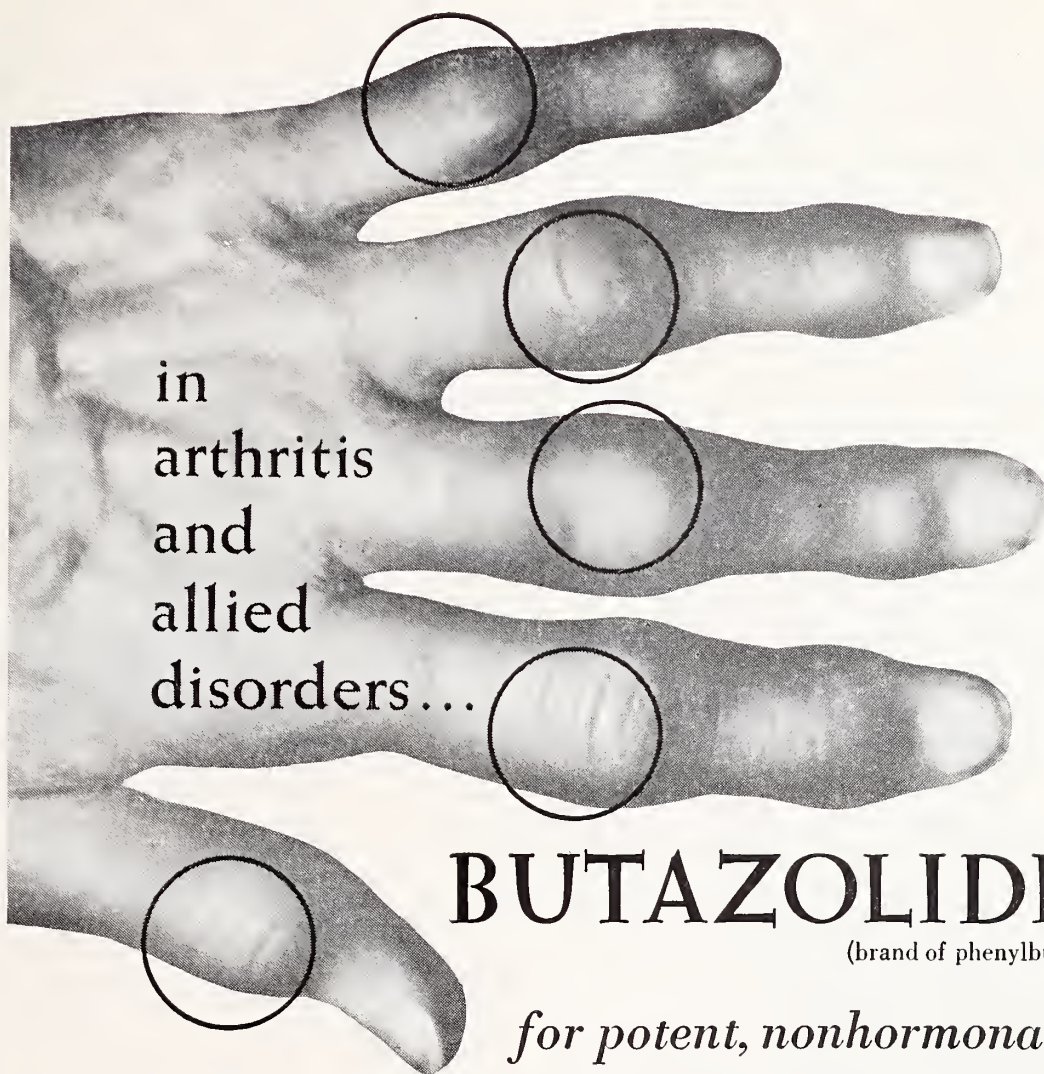
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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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No. 12

## THE LAST ONE HUNDRED YEARS

WILMAR M. ALLEN, M.D., *Hartford*

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*The Author. Retired Director, Hartford Hospital*

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**D**URING my period as pathologist there was often involved, particularly in the chemical division, the concentration of substances necessary for the completion of examinations. I can recall no such concentration approaching that of condensing one hundred years into two or three minutes. I will not attempt it.

The factual history of the Hartford Hospital has already been given by word and in print. One point should be emphasized—the Hartford Hospital, like others, was for the homeless, the poor and the transient till 1906. At that time private patients could be admitted and the institution became a community hospital. Since that time admissions have increased from 2,000 to 33,000.

It is difficult in a brief time to select an important aspect of such a long period. The following seems to be most important.

At the beginning of this period the doctor was a dictator telling people of little skill what to do for his patient. The functions of the dietary, laundry, and housekeeping departments were no more complex than those performed by the household maid of that time. Medications and treatment were such as could be rendered by almost any mother in her household.

Let us speed up the reel of time and see what has happened. The progress of medical, nursing and ancillary care has been phenomenal. With this

progress and the increasing complexity of patient service, the doctor has required more and more assistance. Many functions which he used to perform personally are now provided by many others. Think, for example, of the care of the obstetrical patient in labor; of the administration of transfusions and infusions; of many laboratory and x-ray examinations, to mention a few of the services which the doctor by force of necessity has had to pass over to other skilled minds and hands. Think also of those unseen but vital members, the fireman in the steam plant—no steam, no heat, no sterilization, no cooking, no hospital; the telephone operator—think of transmitting all of those messages in person.

And so by natural evolution there has been developed the patient's team. The doctor is still the captain and always will be, but he is a leader rather than a dictator. Success cannot be achieved by members of a team running in all directions, nor by the captain ignoring his responsibility for leadership of his team. For satisfactory functioning, there are also necessary management, financing, community understanding and backing.

Fie upon those who still cavil about the practice of medicine by nonprofit corporations as represented by the typical modern hospital; woe to those who try to make personal income a matter of ethics; disaster to those who still believe we live in the time of medical dictatorship!

Who has the great privilege of being a member, or even a captain, of a team rendering such a service to his fellow man?—The doctor of medicine—and I am proud to be one of you!

*Presented at annual dinner of Connecticut State Medical Society, April 28, 1954*



## HARTFORD HOSPITAL'S NEXT 100 YEARS

T. STEWART HAMILTON, M.D., *Hartford*

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The Author. *Director, Hartford Hospital*

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PHYSICIANS and hospitals are so intimately intertwined these days that a birthday for one becomes a family affair; your thoughtfulness in helping us celebrate ours will long be remembered, for it is not only a brotherly gesture but a good omen as well.

Dr. Allen has given you an excellent picture of the last century and what it brought. I know of no one who has had a greater hand in shaping the present course of Hartford Hospital. As I face the problem of discussing the next hundred years, even knowing that a poor workman always blames his tools, my lament is that the lenses of my prospectoscope are poorly ground compared with those of that most accurate of all instruments the retrospectoscope. With the assurance, however, that few of us here tonight will be celebrating the bicentennial of Hartford Hospital, let me peer ahead with you through our poor instrument to see what the future may bring.

If the pendulum swings to and fro with equal force, one might conclude that since there was no Hartford Hospital in 1854 perhaps there will be none in 2054 and thus end these remarks. This I do not believe, however, and so I shall, with appropriate hedging, make my forecast. I believe this will happen over the next century to us at Hartford Hospital and to hospitals and the practice of medicine elsewhere in the United States as well:

As our population ages and our medical problems center less on acute communicable disease and more on chronic and degenerative disease, we shall see profound changes. Emphasis will be—it is already—more upon prevention and less upon cure. The present great need for hospital beds for definitive care of the ill patient will diminish. The physician will spend more of his time in watching over the

health of his families than in treating their illnesses after they develop.

The hospital will change far more than the physician, for the physician is already used to practice both in office and hospital and community while we in hospitals have too long clung to the feeling that the doors of our institutions mark a dividing line for us; we attend all the needs of the person inside and do nothing for the person outside. There was good reason for this at one time, but times change and reasons become less valid. The large teaching hospital will become a center, its personnel working closely with others to guard the health of many. While extending its facilities into the community it will receive some patients with minor illnesses, but by and large they will be cared for at the local community hospitals while we shall receive only the complicated cases demanding highly specialized skills. Our health functions will be to work with all the communities we serve to keep in operation the best possible programs of preventive medicine. We shall probably operate the rehabilitation center for the area we serve, sending personnel out to assist at the local level. We shall become as well the research center and this aspect of our activity will expand rapidly to assume its proper role.

The hospital, then, will be the health center for a large area with patients and personnel, both medical and paramedical moving in both directions. But, you say, a hospital cannot practice medicine, and this is very true. In fact, the hospital is people and we are talking of what people will do with regard to health and disease. This brings me to my second point, the doctor and his hospital. Because medical practice is progressing so rapidly that we as individuals can possess little of all there is to be known, we will move toward cooperative practice of one sort or another. As I look ahead I see teams of physicians who will serve whole areas. They will be in groups closely coordinated, not only with one

hospital but with many, as well as the attendant health centers. The doctor will be able to grow within the group, to maintain affiliation with several hospitals, to derive more satisfaction from his practice and will in all probability be able to spend more time with his family. I wish I could see that with all this we are to preserve the doctor-patient relationships of the good old days but I fear that at least in cities these have already greatly changed. No gain is achieved without some loss, but the patient will still live a longer, healthier, more productive and we hope a happier life.

As we look to the distant future we see greater emphasis on the preservation of health, the great problem of keeping our aging population healthy and active and much greater regionalization and

coordination both of preventive and of curative medicine. If we will it enough and work hard enough and set a good enough example, this can be done under our voluntary system. The prodigious strides of the last century have been made largely under the discipline of our own good intentions; this alone should indicate that we can continue to advance by the same means. As we look to see how this can best be accomplished, we must consider the conclusion reached by one practicing physician who said "amalgamation of hospital and staff is the greatest remaining field for improvement of medical service." Whether we accept his thesis or not, as we progress we must strive mightily for ever closer cooperation and coordination, for therein lies our greatest usefulness to our fellow man.

## THE DIAGNOSTIC APPROACH TO DISEASES OF THE LUNGS

EDWARD J. WELCH, M.D., *Brookline, Massachusetts*

**D**URING the last two or three decades, there has been a change of attitude toward diseases of the chest. Physicians used to have to rely on the history, physical examination, and rather inadequate sputum examination in making diagnoses. As a result only advanced disease was diagnosed with any certainty. Even after the advent of the x-ray early diagnosis was unusual. After all, with so little therapy available, there was no hurry about making a diagnosis.

We are still in an era of transition. Great improvements in our diagnostic methods have been achieved. Chemotherapy has come into its own, at least for infectious diseases. The anesthesiologist and the thoracic surgeon have made intrathoracic procedures relatively safe. Advances in therapy have really outstripped advances in diagnostic methods. We are faced with a need to bring patients to therapy before the chance of cure is lost.

There are certain delays with which we are all familiar:

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### SUMMARY

There are many old and new methods of approach to the diagnosis of diseases of the chest. It is important for us to seek early definitive diagnosis in view of the great advances that have been made in therapy. An attempt has been made to outline the tools at hand, and to indicate their use.

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1. Between the onset of the pathologic process and the onset of symptoms.
  2. Between the onset of symptoms and the first visit to a physician.
  3. Between the first visit to a physician and the first x-ray.
  4. Between the first x-ray and the final diagnosis.

The delay between the development of the disease process and the onset of symptoms is still the big



stumbling block to the early treatment of the two major pulmonary diseases, namely, tuberculosis and carcinoma. Surveys with the chest x-ray have begun to make some progress here, but only by periodic chest x-rays in apparently well people can we hope to detect these diseases in their early stages.

That delay which comes between the onset of symptoms and the first visit to a physician is understandable. For years the public was aware of the lack of effective therapy. Fortunately, with improvements in therapy, this period of delay is being whittled away by the education of the public. Some delay of this type, however, will always be with us because people have a certain amount of optimism and expect symptoms to go away. In most cases we must still await the arrival at our office of the patient who has symptoms. By and large, it may be stated that in diseases of the chest a radiologically demonstrable lesion is present before the onset of symptoms. Here is a recognized fact that has led to the mass x-ray surveys throughout the country. Such surveys have great value, but are not feasible at frequent enough intervals to do the job we all want done.

Practically, the clinician cannot attack this problem of early diagnosis until the patient presents himself at the office or clinic. He will come to us because (1) he wants relief of symptoms, or (2) because he has been x-rayed in a survey and a lesion has been found.

#### THE X-RAY SURVEY

First, let us take a look at what part surveys play in diagnosis. Collectively, the medical profession is largely responsible for whatever is accomplished here; and let us consider here the two diseases of chief importance, tuberculosis and cancer.

In the communitywide survey held in Boston in 1949 and 1950, over a half million x-rays were taken. There were 247 new active cases of tuberculosis found. This is a yield of one new case per 2,000 films. In this day of modern chemotherapy for tuberculosis, there is no question of the value of this technique for finding cases. The apparently well individual with pulmonary tuberculosis has an excellent chance of recovery if he is brought to therapy, because of the slow evolution of the disease.

The single survey film is not the whole answer to diagnosis. The survey report may go no farther than to say "pulmonary tuberculosis, activity undetermined." The survey can be no better than the

follow-up, and this is a job that falls to the practicing physician. Practically, we should get serial x-rays of these patients and not feel sure that the disease is inactive until stability of the lesion has been demonstrated for at least six to twelve months. This observation should be combined with careful observation of the sputum and gastric contents for tubercle bacilli.

In this same survey with 536,000 films there were 39 cases of proven bronchogenic carcinoma. In 22 of the 39, pulmonary resections were carried out. This indicates that approximately 25,000 films are necessary to uncover a resectable case of bronchogenic carcinoma.

Of the 22 resectable cases, only 5 were alive and well at the end of a four year follow-up period.<sup>1</sup> These results are most discouraging, but there is room for improvement in survey work for cancer of the lung in two directions. First of all in this series there was a fifty-six day average delay between the survey film and the final diagnosis. Secondly, the Philadelphia group<sup>2</sup> found that the yield of cases was 1 per 600 films when only those over the age of forty-five were x-rayed. In males over the age of forty-five the yield was 1 per 400 films.

These figures give us a rough idea of what part surveys may be expected to play in diagnosis. Unfortunately, with regard to carcinoma, x-rays will detect only those tumors large enough to stand out on the films as a mass, or large enough to cause distal suppuration, atelectasis, or obstructive emphysema. We must admit that the discovery of bronchogenic carcinoma in x-ray surveys has not yet improved the results in the patients thus detected over the results in patients seeking a physician's advice because of symptoms.

After this brief look at the survey record let us turn to the patients who come to us with symptoms. How do we proceed to diagnosis?

#### HISTORY AND PHYSICAL EXAMINATION

We must not neglect our earliest training in history taking. If the patient's complaint suggests pulmonary disease, we must remember to check a few important things such as:

(a) Is there a history of contact with tuberculosis? Has the patient lived where there is endemic pulmonary disease? Without such knowledge we may miss early diagnosis of tuberculosis, coccidioidomycosis, histoplasmosis, or blastomycosis.

(b) Has the patient been using mineral oil by

mouth or in nose drops? That process at the base of the lungs may be a lipoid pneumonitis.

(c) What is the patient exposed to in his daily work—what dust or chemical? A diagnosis of pneumoconiosis or of chemical pneumonitis requires such a history.

Now physical examination does not often give much help in early diagnosis but may give some. Early lesions will not cause alteration of the thoracic resonance or tactile fremitus. The presence, however, of auscultatory ronchi, rales or friction rubs may be of help and may be early findings. In addition to the examination of the chest itself, some of the chief findings of aid in diagnosis are:

(a) The presence of palpable lymph nodes, liver and spleen. These organs may be enlarged in sarcoidosis, lymphomata, and advanced carcinoma.

(b) The presence of clubbing of the fingers. Usually clubbing means chronic disease, but occasionally appears early in carcinoma of the lung.

(c) The presence of phlebitis or of phlebothrombosis of the legs. Many an hemoptysis has had its origin at this distant point.

The history and physical examination are only superficially dealt with in this presentation, because I expect that we all do these as a matter of routine. However, I would emphasize here that early disease of the lungs is rarely detectable by physical examination.

#### X-RAY AND FLUOROSCOPIC EXAMINATION

Having our suspicion raised by either the history or physical examination, the next step is to get a chest x-ray. The chest is one portion of the body where the x-ray may give considerable diagnostic aid. There should be no delay in the office patient with a history or physical examination suggestive of pulmonary disease.

Here is one type of delay, mentioned above, for which the physician is often responsible. If the patient's symptoms are of short duration, some tact is required in "selling" him an x-ray. That cough of one week's duration may be your only warning that the patient has bronchogenic carcinoma, and less than a year to live if not treated at once! Once symptoms develop, it is unusual for the untreated patient to live a year.

In the home, of course, it is logical to treat acute disease, such as pneumonia, first, but be sure that an x-ray is taken when the patient is well enough to go

out for it. A word of caution here—if the x-ray confirms a clinical diagnosis of pneumonia, follow the patient with repeat x-rays until clear. Following such patients carefully, the few whose acute pneumonitis is due to cancer or tuberculosis will be correctly diagnosed at the earliest possible time.

When pulmonary disease is suspected, the conventional 14" × 17" film should be used. Photo-fluorograms should be reserved for survey studies of apparently well people. Statistically they do not have quite the same accuracy as the larger films. Remember also that the radiologist has other tools at hand in addition to the plain film. Lateral views often help in localization of lesions seen on the P-A film, and may bring to light retrocardiac disease not seen on the P-A film. Stereoscopic films, obliques, over exposed films all help in special cases. Tomography (also known as laminagraphy, planigraphy, and body-section radiography) is a technique growing in popularity. A series of films may be taken in which both the tube and cassette move, blurring out the dense structures of the thorax and focussing at desired levels. Such techniques have revealed intra-bronchial tumors, vascular tumors, and tuberculous cavities not otherwise shown by the x-ray. It is a time-consuming, relatively costly procedure that has, however, much value in selected patients. Lordotic or apical views often bring densities out from behind the ribs and clavicles and are increasingly popular in the observation of tuberculous patients.

The fluoroscope should also be mentioned here. It may give useful information regarding ventilation. The trapping of air in one lung or pulmonary segment may be demonstrated in expiration, leading to a suspicion of bronchostenosis. The low position of the diaphragms and their failure to move in respiration may be the best lead to the degree of dysfunction in pulmonary emphysema. Masses may be observed for the presence or absence of pulsation. However, for the fine detail of pathology in the lung, fluoroscopic examination is greatly inferior to the x-ray film.

Bronchography with iodized oil is a useful radiologic procedure in some cases, particularly where the question of bronchiectasis is raised. If iodized oil is coughed into the alveoli, however, it may obscure interpretation of subsequent films for many months. Newer, more rapidly absorbed mediums are being investigated and may replace the oily



medium in use at present. Bronchography has its greatest value in mapping out the extent of bronchiectasis in planning surgical therapy. Diagnostically it is most useful in the patient who has a hemorrhage from a chest that appears normal by x-ray and bronchoscopic examination. It may bring localized bronchiectasis to light.

Angiography has only a limited field of usefulness. Suspected mediastinal tumors may be identified as aneurysms; suspected aneurysms may be shown to be tumors distinct from the vascular system. Recent studies have shown that the increased vascularity of resolving pneumonitis can be distinguished from the relative avascularity of neoplasm.<sup>3</sup>

#### SPUTUM EXAMINATION

Having arrived at the x-ray picture stage, we must in many cases move on for more information. The radiologist can usually suggest possibilities, but cannot make conclusive diagnoses. We must examine the sputum.

##### (a) Bacteriology.

Although the gross examination of the sputum will tell us whether it is bloody, purulent, or foul-smelling, or whether it contains the caseous material suggestive of tuberculosis, more detailed examination is usually desired. It is true that the days of painstaking routine bacteriologic studies in acute pneumonia are over. The typing of pneumococci has little or no place in a medical program that includes penicillin. Sputum testing, of course, does become important when there is no response to the drug. Then we want to know if tubercle bacilli are present, or other organisms such as the Friedlander bacillus that are not sensitive to penicillin.

With regard to tubercle bacilli, examination of the sputum is not conclusively negative until the laboratory examination has progressed from the smear to the concentrated specimen, and to the culture or guinea pig inoculation. A routine smear for acid fast bacilli will detect these organisms only if present in great numbers. It is estimated that 10,000 to 100,000 organisms must be present per cc. of sputum before the routine smear will be found "positive." In patients who do not raise sputum but swallow it unconsciously, cultures of the fasting gastric contents will often reveal the organism. Where fungus disease is suspected because of the patient's previous residence in endemic areas, the sputum should be cultured on Sabouraud's medium. The presence of coccidioides, histoplasma, blasto-

myces or nocardia is of diagnostic significance. Other fungi are usually secondary invaders, or may normally be found in the flora of the mouth or may be common laboratory contaminants. Cultures are extremely important where fungus disease may be present as the x-ray picture in these diseases may mimic almost every other pulmonary disease. In New England, of course, fungus diseases are very rare.

##### (b) Cytology.

Where bronchogenic carcinoma is suspected, cytologic examination of the sputum by the Papanicolaou technique is indicated. When bronchogenic carcinoma is present, this test may reveal malignant cells in 70 per cent to 80 per cent of cases. The following figures from a series studied at the Mayo Clinic are of interest.<sup>4</sup>

#### CYTOLOGY OF SPUTUM AND BRONCHIAL SECRETIONS

Total number of patients with pulmonary disease.....	588
Bronchogenic carcinoma (proven).....	147
Positive on cytologic examination.....	100
Positive on first test.....	75
False positives .....	0

The value of this type of examination is emphasized by the lack of false positives and by the considerable number of positive first tests. Farber and others<sup>5</sup> found in a retrospective study of 60 proven cases of bronchogenic carcinoma who had had five cytologic examinations of the sputum that a positive result was obtained in 90 per cent.

#### PLEURAL FLUID

Where fluid in the pleural space presents itself, aspirations and examination should be carried out. Pleural fluid in the young adult is usually due to tuberculous pleurisy with effusion, and may appear in the absence of recognized pulmonary lesions. Even the most careful bacteriology of the fluid will rarely yield more than 60 per cent of positive cultures for tubercle bacilli. The high incidence of subsequent tuberculous disease in these patients, however, is sufficient to warrant diagnosing them as tuberculous pleurisy with effusion in order that they may receive proper therapy.

Although we may see tuberculous pleural effusion in older people, other causes such as cancer and heart disease should be sought. The fluid may be submitted to bacteriologic and cytologic examination. Attention should also be paid to the specific gravity in distinguishing exudates from transudates.

## SKIN TESTS

Just a word about tuberculin tests. A properly performed Mantoux test will occasionally help by ruling out tuberculosis if it is negative. The only "false negatives" are in patients with overwhelming, terminating tuberculosis. Never treat a bacteriologically negative patient for pulmonary tuberculosis until you have demonstrated a positive tuberculin test. The only exception to this rule is the occasional patient with "miliary" disease whose tuberculin test may be temporarily suppressed by the overwhelming infection.

Test substances from some fungi such as histoplasmin and coccidioidin are available for use in patients from areas of endemic fungus disease. A positive skin test may give you a worthwhile lead toward diagnosis. The tests are not in themselves diagnostic, but if negative probably exclude certain diseases from consideration.

## BRONCHOSCOPY

In the series of 147 cases of proven bronchogenic carcinoma studied at the Mayo Clinic, there were 93 bronchoscopic examinations. A positive biopsy was obtained in 38 of the 93 (40 per cent). Sixty-five of these 93 had positive cytology of the sputum or bronchial secretions (70 per cent). These figures are consistent with those generally reported: namely, that not over 50 per cent of all cases of bronchogenic carcinoma have a tumor that can be seen and a biopsy specimen taken through the bronchoscope. I think it is safe to say that if we learn to recognize bronchogenic carcinoma early, the percentage of bronchoscopically visible tumors will be even smaller.

The bronchoscopist may also obtain important information by observation of the vocal cords for the presence or absence of fixation of the trachea or carina. He can tell us which lung or which lobe is producing hemoptysis, and it is important in cases where the site of origin is in doubt to have the patient examined with the bronchoscope while still bleeding. Bronchoscopy is also of value in demonstrating tuberculous bronchial disease and obtaining secretions for study where sputum is not raised.

## BIOPSY

One of the newer techniques in biopsy first reported by Daniels<sup>6</sup> in 1949 is commonly referred to as "scalene node biopsy." This is a technique growing in popularity because of its yield of information. In brief, an incision is made in the angle

between the lateral border of the sternocleidomastoid muscle and the clavicle. The floor of the space that is entered is the scalenus anticus muscle. This space contains a pad of fat in which there are lymph nodes which communicate directly with the mediastinal lymph nodes. Shefts and others<sup>7</sup> have shown that in patients with previously undiagnosed disease, these nodes may yield diagnostic information in better than one-third of all patients.

This is a useful procedure, particularly when there are no palpable lymph nodes for biopsy, and when it is desirable to know, if possible, the contents of the mediastinal lymph nodes. Where the lesion or mediastinal enlargement is unilateral, the operation should be done on the homolateral side. Where the problem is one of more diffuse bilateral disease, the biopsy specimen should be taken first on the right side, and if negative may be repeated on the left. This is because of the occasional injury of the left thoracic duct when operation is done on the left. If the exploration is carried deeper into the mediastinum, complications will be more numerous, but some authors recommend this extension of the operation when the scalene fat pad seems to be relatively lacking in lymphoid tissue. At the time of biopsy, tissue should be submitted for culture for tubercle bacilli and for fungi, as well as a specimen for tissue pathology.

Sarcoidosis is the disease that has been most often confirmed by this procedure. Bronchogenic carcinoma of the undifferentiated type is often revealed, and in the third place is tuberculosis. Other conditions that have been identified by this technique are histoplasmosis, Hodgkin's disease, lymphosarcoma, silicosis, and carcinomas other than pulmonary.

Aspiration biopsy through a needle has achieved no popularity as a diagnostic tool for lesions in the lungs. Pneumothorax, empyema, hemorrhage, and spread of the tumor along the needle tract are possible serious complications of this technique. If it is to be used at all, it should probably be restricted to the indication outlined by Dutra and Gerarci.<sup>8</sup> They restrict its use to obviously incurable cases in which histologic or bacteriologic diagnosis has not been attained by other methods, and in which definitive diagnosis might lead to palliative chemotherapy or radiotherapy.

## THORACOTOMY

Thus far I have attempted to outline those methods of approach to diagnosis which fall short of major surgery. These methods, however, often fall



short of diagnosis, and when diagnosis is imperative thoracotomy should be undertaken.

There is no longer much argument about the solitary lung lesion. If it is not well calcified, if it is in a patient over thirty-five years of age, and if its identity has not been established by the measures I have outlined within a period of two or three weeks, then it should be explored. Only such an aggressive approach will offer a cure to the patient with bronchogenic carcinoma. The risk of such an approach is very small indeed. In the natural history of any bronchogenic carcinoma there comes a moment when the fateful metastasis occurs. There can be no "observing" by serial x-rays the patient whose lesion may be cancerous. There can be no waiting for prolonged sputum cultures.

With regard to more diffuse lesions in the lungs, direct lung biopsy may at times be worthwhile. For example, it may save the patient with sarcoidosis from being treated for long periods of time for miliary tuberculosis. The demonstration of sarcoid disease may lead to beneficial therapy with cortisone, yet one would not wish to proceed with cortisone if tuberculosis were present. Lung biopsy is useful in establishing diagnoses, and in enabling the physician to give some indication of prognosis. It must be admitted, however, that in diffuse pulmonary diseases, the procedure should be reserved for cases in which the diagnosis has not been demonstrated by any other means, and in which the findings of biopsy may influence therapy. Again we are dealing with a procedure that has become safe in the hands of capable thoracic surgeons. If the obviously moribund patient is excluded, there should be no mortality from the procedure.

Open thoracotomy may also be indicated where there is obvious mediastinal disease, the nature of which has not been indicated by scalene node biopsy. It is probably unwise today to try first a dose of irradiation, a practice not uncommon a few years ago. Mediastinal enlargements that disappear following radiotherapy may actually be uninfluenced by radiotherapy and be undergoing spontaneous retrogression. If the tissue pathology is known, we can save ourselves and our patients a lot of worry with regard to prognosis, and avoid a great deal of unnecessary follow-up observation in certain benign lesions.

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## MANAGEMENT OF RECURRENT INTESTINAL OBSTRUCTION

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**F**EW physicians have escaped being called upon to manage cases of recurring intestinal obstruction; all appreciate the magnitude, the severity, often the hopelessness, generally the pathos involved in the problem. Those afflicted are victims of intermittent attacks of severe to excruciating abdominal pain. Malnutrition, frequent abdominal laparotomies, and morphine addiction are not uncommon; a psycho-neurotic overlay is bound to complicate the picture.

The etiology of recurrent intestinal obstruction is manifold. By far the commonest cause is adhesions, particularly when matting together and ensnaring of the small intestine occur; adhesions, in turn, may be the result of abdominal surgery, inflammation, ascites, talc granuloma, trauma, and hemoperitoneum. Less commonly, recurrent obstruction may be caused by abdominal carcinomatosis, malrotation of the bowel, regional enteritis, and tumors.

The diagnosis is a challenge. Naturally, when complete obstruction follows in the course of the disease, it is not difficult to evaluate the situation, particularly in view of a past history and in expectation of such an event. The real problem centers upon the establishment of a proper diagnosis during the interval phase, or during attacks precipitated by partial intestinal obstruction, for, as has been indicated above, psychoneuroses generally become so integral a part of the condition as to often confuse, or become indistinguishable from the organic lesion.

The clinical picture generally evolves as follows: the patient reports to his family doctor, complaining of recurrent bouts of cramp-like abdominal pain, with or without vomiting, constipation, and possibly slight distension; there is a history of an abdominal operation, generally several operations. No abnormal findings are discernible on physical examination. The patient is usually labelled "spastic," is placed on a regime of antispasmodics, sedation, and bland foods. Temporary relief is afforded, but recurring attacks of partial intestinal obstruction or "pulling on the

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### SUMMARY

Recurrent intestinal obstruction presents one of the most trying problems facing the patient, family doctor, internist, and surgeon. What is believed to be a practical plan of management consists of the following:

Mild cases are treated with sedation, antispasmodics and psychotherapy. Occasional hospitalization for intubation and parental feedings to tide over acute attacks is feasible. Severe cases, despite psychogenic implications, should be subjected to operation. If there is no organic basis for the clinical picture, then psychiatric care can be pursued vigorously and with full confidence in the diagnosis. Organic causes are contended with in accordance with the nature of the pathology: tumors are attacked directly; irremovable causes such as adhesions, carcinomatosis, malrotation of the bowel, inflammatory diseases of the small intestine, talc granuloma, etc., are indications for pleating of the small intestine. This is accomplished by drawing a Satinsky tube tautly through the small intestine, fixing it proximally at the nose or jejunostomy, and distally to the skin via a cecostomy, or ileostomy. Manipulation of the serosa and a natural tendency toward fibroplasia promotes sufficient adhesions to replace the function of the tube which is thereafter removed. Other features of the tube, namely, the wide bore, semirigidity and multiperforations, mitigate against kinking, atresia, and closed loop obstruction. Moreover, by providing complete intestinal rest, the Satinsky tube may prove useful in the treatment of acute, progressive regional enteritis.

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bowel" are generally more severe, necessitating the administration of narcotics. The patient is now on his way to addiction, for the pain experienced truly requires desperate measures.

X-rays sooner or later are ordered, either by the family doctor, internist, or gastroenterologist. As a rule, the x-rays are negative. Occasionally the report reads, "some pooling of barium in some of the loops of small intestine."

Several courses are now open to the physician and are followed alone or in combination:

(a) The patient is continued on intensified treatment, yet malnutrition, recurrent pain, and narcosis persist; in effect, the patient becomes an intestinal invalid. A more acute obstruction may bring the patient to the hospital for parenteral feedings and decompression by intubation; after a few days medical measures are resumed. Physical and mental distress for the patient, invariably exacting both anxiety and various sacrifices from family and friends are the rule; financial resources are drained. An unhappy prospect at best!

(b) The patient may be referred to the psychiatrist as a case of hysteria. If an organic lesion is underlying, treatment is costly and futile.

(c) The patient may be referred to a surgeon, who in turn may:

1. Consider the findings insufficient to warrant surgery, relegating the patient to a demoralizing future. (Indeed, one patient with organic disease, previously labelled a neurotic, stated that she would "rather have cancer than my pains; at least I know the suffering would be over soon.")

2. Subject the patient to abdominal laparotomy. If areas of small bowel distortion due to adhesions are found, the surgeon will pursue one of the following courses:

- a. Do nothing, aware that mobilization of the bowel will only result in recurrence of adhesions, and that such mobilization may in itself prove hazardous.

- b. Perform simple lysis of adhesions, feeling that "at least something is done."

- c. Mobilize the bowel and attempt to prevent the formation of adhesions by the employment of one of the numerous methods described in the literature: viz., intraperitoneal installation of heparin, saline, oil, hyaluronidase, pancreatic enzymes, amniotic fluids; the administration of cortisone to promote fibrolysis; prostigmine or pituitary extract to pre-

vent adhesive fixation by increasing bowel mobility, etc. Unfortunately, all these adhesion-prevention measures have proved fruitless.

- d. The surgeon may elect to control adhesion formation by the suture plication method advocated by Nobel and others. Of all approaches, this has been the most logical but does, in itself, admit of certain serious complications such as post-operative obstruction due to angulation and leakage at the suture line with resulting peritonitis and/or fistula formation.

From the above outline one would conclude that the management of recurrent intestinal obstruction still remains trying, to say the least. The authors feel, however, that since the introduction of a new surgical technique previously reported,<sup>1</sup> a sequence of therapeutic measures may now be logically and confidently applied.

The previously enumerated, simple, direct non-surgical attacks should, of course, be undertaken first and foremost. Coupled with psychotherapy administered by the family doctor, satisfactory results may be obtained. It is the resistant cases that require the exercise of astute judgment. Every case is afforded psychiatric consultation. At first we acquiesced almost completely to the opinion of the psychiatrist. Experience, however, demonstrated that such opinions, even rendered by the most skillful, too often proved unreliable, so complicated are the psycho-organic interactions; errors have been committed on both sides of the issue. The more costly error, of course, occurs when surgery is denied.

A particular dramatic case in example is worthy of mention.<sup>2</sup> A middle-aged male complained of recurrent severe abdominal pains for one year; physical examination was negative. The last attack led to admission to a psychiatric hospital where he was treated for one week. During this time, the pain increased in severity. Finally, when signs of peritoneal irritation developed, he was subjected to immediate operation. Intestinal obstruction secondary to old adhesions was found. Gangrene, with multiple perforations of the small bowel, had resulted in a widespread peritonitis which, unfortunately, proved fatal.

Now, with a method available for the prevention of recurrences, all things being equal, exploratory laparotomy should be performed in practically all questionable cases. Laparotomy is relatively simple and, indeed, is often performed with impunity with presenting symptomatology far less debilitating and

agonizing than in these cases. If patients are suspected of being "surgery prone," a "final operation" will decide the matter once and for all; previously there was no safeguard against recurrence and records were of little value, since practically always the surgeon described "some adhesions." Surely, if the adage "better to remove nine normal appendices than miss one perforated one" is accepted, then too, this precept should obtain: "Better to perform nine fruitless abdominal laparotomies than miss one case of organically incurred recurrent intestinal obstruction." Certainly, patients suspected of suffering from recurrent intestinal obstruction should be hospitalized for a final evaluation, which should include complete laboratory, gastrointestinal roentgenograms, and gastroenterologic and psychiatric consultations. Exploration is carried out if:

1. The clinical picture favors the diagnosis of recurrent intestinal obstruction.
2. X-rays indicate any abnormality in configuration or motility of the small bowel.
3. Previous records of surgery do not attest to the complete absence of adhesions, and there are no medical or psychiatric contradictions to surgery.

Once surgery has been decided upon, the method recommended by the authors in the communication previously referred to is carried out. Briefly, this method consists of mobilizing the bowel, then threading through it a long, semirigid, wide bored, multiperforated rubber tube.\* Passage of the tube is facilitated by attaching it to a Miller-Abbott tube, which is preferably passed two or three days prior to operation. A stab wound is made in the R.L.Q. of the abdomen for the establishment of a small cecostomy. The Miller-Abbott tube is then pulled out through the cecostomy, followed by the Satinsky tube, the end of which is secured to the skin by wire suture. Now the anesthetist is instructed to withdraw the Satinsky tube from the nose. This maneuver causes all the small intestines, riding over the tube, to become bunched together, much like an accordion, or the pursing of a tobacco pouch by pulling the threads taut; the bowel now "swings," as it were, on a relatively short tube. The resulting pleated arrangement of the bowel is then maintained by fixing the tube to the nose by means of adhesive tape or, preferably, by wire suture (Figure 1). Efforts are now made to promote adhesions instead



FIGURE 1

Photograph at operation showing pleating of small intestine by means of tautly fixed Satinsky tube. (Courtesy of the *Journal of the Albert Einstein Medical Center*.) The payr clamp is no longer used for distal fixation; it is wiser to employ nonobstructing wire suture. (See text.)

of trying to prevent them, by deliberate manipulations of the intestinal serosa. The tube is held in position for four to six days, until adhesion formation serves to fix the bowel in this arrangement. No sutures are used. The rubbing of the serosa, together with the patient's natural tendency to fibroplasia, insure sufficient adhesion formation to bind the bowel in its new pleated configuration.

In certain situations it may be expedient to introduce the Satinsky tube by way of a rapidly established jejunostomy. Such situations may obtain when the "lead" Miller-Abbott tube fails to pass into the small bowel preoperatively and cannot be passed with ease during operation. Moreover, if the patient's condition is critical, as so often is the case in the acute phase of recurrent intestinal obstruction, it is generally prudent to forego prolonged manipulative attempts to pass the Miller-Abbott tube beyond the pylorus, and be content with the immediate passage of the Satinsky tube via a jejunostomy.

\*The Satinsky Tube may be procured from George C. Pilling & Sons Company, Philadelphia 4, Pa.



Distally, modifications include fixation of the tube through an ileostomy, if one exists or becomes necessary by virtue of a required resection. Fixation of the tube in the cecum by means of a balloon attachment is also feasible, though not recommended.

The proximally-distally fixed Satinsky tube serves three purposes:

1. With the application of constant suction, the multiple perforations along the tube assures decompression of every segment of small intestine, thus offsetting the catastrophic effects of closed-loop obstruction.

2. The wide bored, semirigid construction of the tube acts as an intestinal prosthesis, preventing obliterative obstruction, and at all times assuring an adequate lumen.

3. The pleated arrangement of the bowel, at first imposed by the fixed tube and subsequently maintained by controlled adhesion formation offsets the possibility of intussusception, volvulus, kinking and other forms of mechanical obstruction.

In recurrent obstruction due to malrotation of the bowel, the authors have postulated<sup>1</sup> that an additional desired effect is obtained by reducing the length of the bowel to conform with its congenitally short attached mesentery. With the disproportion of bowel to mesenteric attachment overcome, there is less likelihood for volvulus to occur.

Postoperatively, patients are maintained on parenteral fluids until peristalsis becomes manifest. The tube meanwhile remains in situ for four to six days. While adhesions begin forming immediately, this time interval will permit strengthening of the adhesions, vouchsafing better results. The tube is removed proximally after releasing both points of fixation. There may follow a transient period of diarrhea; except for this, there are no physiologic disturbances. The question has been repeatedly raised: "The bowel is shortened. Doesn't this interfere with its function?" A negative answer is explained by the fact that anatomically and physiologically the bowel is not shortened; only its topographical configuration has been altered. The same absorptive and secretory surface is still present and functions normally with the return of peristalsis. Indeed, one may compare the functioning surfaces now available to that offered by the convolutions of the brain, or by the relatively small area occupied by 70 square meters of pulmonary capillary bed. Again, the bowel has not been shortened; it has only become convoluted instead of extended.

The procedure briefly described has a variety of applications. Under no circumstances is it designed to replace direct attack on primary lesions causing recurrent obstruction, such as small bowel tumors. Its only concern is with the treatment and prophylaxis of recurrent intestinal obstruction where the etiologic agent cannot be eradicated.

The method described has been employed in eleven (11) patients; 2 males, 9 females. All cases were of serious magnitude. There were three deaths. Previous operations ranged from one to seven, with an average of three. Six cases were operated on in the acute phase, five during the chronic.

The etiology of the obstruction represented a wide range of pathology (Table I). The various methods of fixing the tube are represented in Table II.

TABLE I  
ETIOLOGIC FACTORS UNDERLYING RECURRENT INTESTINAL OBSTRUCTION

CAUSE	NO. OF CASES
1. Diffuse regional enteritis.....	1
2. Malrotation of the bowel.....	1
3. Metastatic carcinoma .....	1
4. Talc granuloma .....	1
5. Multiple adhesions, postoperative.....	6
(a) simple appendectomy .....	(2)
(b) perforated appendicitis .....	(1)
(c) pan hysterectomy .....	(1)
(d) simple cholecystectomy .....	(1)
(e) subacute hemoperitoneum secondary to ruptured ectopic pregnancy and postoperative salpingo-oophorectomy .....	(1)
6. Old perforated, active gastric ulcer.....	1

TABLE II  
SITES OF FIXATION OF SATINSKY TUBE IN SMALL BOWEL

PROXIMAL FIXATION	COMBINATIONS		NO. CASES
	DISTAL FIXATION		
a. Nose	ileostomy		3
b. Nose	cecostomy		4
c. Jejunostomy	ileostomy		1
d. Jejunostomy	cecostomy		3

Results have been most gratifying. Those surviving surgery have given no evidence of recurrent intestinal obstruction. The longest period of observation has been six years. The case of talc granuloma particularly demonstrates the efficacy of the procedure. The afflicted 27 year old female had seven operations within four years, and was an

"intestinal invalid;" she was confined to bed practically the entire day and had become addicted to morphine. Following her "final operation" in October, 1952, she has had no recurrence. However, while her bowel was "straightened out" her psychological problems have yet to be fully untangled.

A brief discussion of the mortalities is warranted, particularly in view of the lessons to be learned.

The first death occurred in a 62 year old female who for years had daily attacks of epigastric pain, associated with anorexia and weight loss. At operation the small intestine was greatly distorted by dense adhesions resulting from an old perforated gastric ulcer, which was still present. In addition to a subtotal gastrectomy, the plication procedure was carried out. The patient expired two months after operation following a series of uncontrollable complications. These included an intra-abdominal abscess which resulted in multiple ileal fistulae. The complications were apparently unrelated to the procedure but were evidently favored by the poor nutritional state and lack of resistance on the part of the patient. Possibly a minute tear in the bowel may have been overlooked during its mobilization.

The second mortality occurred in a 48 year old male who, four days following a simple appendectomy for suppurative appendicitis, was explored because of signs of strangulating small bowel obstruction. Complete obstruction by multiple adhesions was found and the above described method was carried out. The tube was fixed at jejunostomy and cecostomy. A clamp was placed across the tube at the cecostomy and suction applied at the jejunostomy end. The patient expired the next day. At autopsy the entire small bowel was distended and discolored, due to the fact that both the cecostomy and jejunostomy were obstructed, the former by the clamp and the latter by a plug in the tube.

Following this catastrophe, the method of open distal fixation was established. The need for this precaution cannot be over emphasized.

The third death tragically involved a 26 year old female who developed acute obstruction 6 days following salpingo-oophorectomy for ruptured ectopic pregnancy. The obstruction was found to be due to multiple adhesions. Jejunostomy and cecostomy were utilized for fixation of the tube. During the procedure, strong suction was applied to both ends of the tube to obtain more rapid decompression. Signs of peritonitis rapidly developed on the eighth postoperative day; despite intensive therapy, the patient expired within 24 hours. At autopsy, peritonitis was found to be due to multiple perforations of small bowel resulting from minute areas of gangrene, due to sucking in of bowel wall into the holes in the Satinsky tube.

While in the second death we learned never to clamp the distal end of the Satinsky tube to facilitate fixation, by this regrettable death we were impressed with a second never: Never apply suction to the tube unless one end is open to serve as an air vent, thereby preventing sucking in of the mucosa.

Finally, it should be emphasized that both ends of the tube should be irrigated at regular intervals to assure complete patency of both the lumen and aperatures.

# CONCLUSION

With failure of medical management of chronic intestinal obstruction, the patient should not be labelled psychoneurotic until offered the benefit of an innocuous abdominal laparotomy. In the absence of pathology, psychotherapy can then be pursued unequivocally. If adhesions, on the other hand, are found to be the basic cause of the symptomatology, then plecting of the small intestines by means of the Satinsky tube is in order.

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## CAT SCRATCH DISEASE

## Report of Case Presenting Hepatosplenomegaly

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CAT scratch disease is a relatively new disease entity which has been the subject of numerous reports since its initial description in France by Debré in 1950,<sup>1</sup> and in America the following year.<sup>2</sup> The ubiquity and protean manifestations of this disease have become increasingly evident from the more than 200 cases discussed in the literature. In a recent report on 160 cases, Daniels and MacMurray<sup>3</sup> have thoroughly reviewed the literature. The disease is characterized by subacute regional lymphadenitis usually preceded by a small maculovesicular skin lesion. Most patients give a history of contact with cats and about half have sustained a cat scratch in the region drained by the affected nodes. In about one-third of the cases the lymph nodes become suppurative and rupture, although they nearly always heal spontaneously without scarring of the skin. The course of the disease, particularly in adults, is usually mild with moderate fever and only slight constitutional symptoms. Although instances of "cat scratch encephalitis" have been recorded,<sup>4</sup> the central nervous system is infrequently involved. The diagnosis is based on the history of contact with cats, the clinical manifestations, a positive skin test, the histological picture of excised lymph nodes and the exclusion of other diseases. The intradermal test appears to be specific, although it must be interpreted with reservation since the test has been shown to remain positive for at least four years following infection.<sup>3</sup> This test employs antigen prepared from affected lymph nodes of patients with the disease. The material is prepared and the test carried out in a manner similar to that used in the Frei test. Clinically, the disease may be confused with tularemia, lymphoma, tuberculosis, pyogenic lymphadenitis, infectious mononucleosis, lymphopathia venereum, sarcoidosis, sporotrichosis, subcutaneous abscess, infected sebaceous cyst and virtually any disease involving lymph nodes. In addition to this more commonly recognized cutaneous-glandular form,

## SUMMARY

The clinical features of cat scratch disease are briefly reviewed. The protean character of the disease is emphasized in the report of a case demonstrating hepatosplenomegaly. This finding has not been described previously. Tests of liver function early in the disease and a liver biopsy later were within normal limits. Another unsuccessful attempt to isolate the presumed virus of cat scratch disease is reported. Tissue cultures employing monkey kidney were used. The diagnosis of this disease is important since it often resembles more serious disorders.

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the disease may occur in a pseudovenereal,<sup>5</sup> oral,<sup>6</sup> or oculoglandular form.<sup>7</sup>

It is generally believed that a virus akin to the psittacosis-lymphopathia venereum group is the causative agent. This assumed relationship is based on the frequently positive complement fixation reaction to Lygranum (R) and clinical similarity to lymphopathia venereum. Investigation has been hampered by the failure to isolate a specific etiologic agent in experimental animals. Inoculation of infected material into cerebrum, peritoneum, skin, buccal mucosa, conjunctiva and vascular system of birds and mammals, including cats, has failed to produce recognizable disease.<sup>3</sup> It has been reported, however, that the disease has been transmitted by intracutaneous inoculation in a single human volunteer and in several monkeys.<sup>9</sup> The case to be reported was of particular interest because of the presence of hepatosplenomegaly. This finding has not been hitherto described and has, in fact, been said not to occur.<sup>10,11</sup>

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## CASE REPORT

A 45 year old white, night watchman was admitted January 8, 1953 complaining of "swollen neck glands." For about one week a small papule had been present over the right triceps area. Six days before admission he first noted a soft tender mass in the left side of his neck. On the following day there was a similar mass in the right axilla. He had experienced feverish sensation two or three times daily and had recorded a temperature of 100.4° F. on the day prior to admission.

There was no known exposure to infectious disease or history of a similar illness in other members of his family. There were two cats in the household that he occasionally played with; however, he vigorously denied having been scratched recently. He recalled scratching a "pimple" on the left side of his neck about five days before the mass appeared.

Physical examination disclosed a well nourished middle-aged male in no acute distress. There were two papules each about 4 mm. in diameter, one overlying the left submaxillary region, and one over the right triceps muscle. These showed slight peripheral erythema and induration of the base. On the left side of the neck beneath the skin lesion there was a tender fluctuant mass measuring about 4 cm. in diameter. Somewhat smaller posterior cervical nodes were felt on the right. A fluctuant node 6 cm. in diameter was palpated in the right axilla. Both liver and spleen were palpable 3 cm. below the costal margin and the latter was tender.

Initial leucocyte count was 15,700 with 63 per cent neutrophils, 34 per cent lymphocytes, 2 per cent monocytes, and 1 per cent eosinophils. Hemoglobin was 12 Gm.; sedimentation rate, 10 mm./hr. (Wintrobe); urinalysis, normal. Serological tests for the following diseases gave normal or negative results: syphilis, tularemia, brucellosis, typhoid, paratyphoid, typhus, rickettsialpox, "Q" fever, Rocky Mountain spotted fever, and infectious mononucleosis. Complement fixation tests for lymphopathia venereum on paired specimens of serum obtained on the 10th and 25th day of disease gave identical results—(1 plus reaction with 1:10 dilutions, 3 plus with 1:5 and 4 plus with 1:25). Liver function tests including bromosulfalein, cephalin flocculation, thymol turbidity, and alkaline phosphatase were normal. Stool examinations for blood, ova and parasites, were negative. Cultures of excised lymph node and of bone marrow done especially for brucella and *B. tularensis* were sterile. Blood cultures were sterile. Sternal marrow obtained by needle was interpreted as showing normoblastic hyperplasia. X-ray of the chest revealed no abnormality.

The patient was febrile for the first two days only. Lymph nodes, liver and spleen returned gradually to normal size and splenic tenderness disappeared. The skin overlying the involved nodes remained intact. On the sixth day an intracutaneous test with cat scratch skin test antigen\* was performed. At 48 hours the test was positive showing a 2 cm. area of erythema surmounted by a small papule. Skin tests with Lygranum (R) and purified protein derivative #1 were negative; purified protein derivative #2 was positive. On the twelfth day, the right axillary lymph node was removed and

fifteen days later a left cervical node was excised. A needle biopsy of the liver was done on the eighteenth day and revealed normal parenchyma. Both of the nodes were enlarged but not tender and the liver was no longer palpable when the specimen was obtained. The patient was seen in apparent good health three months after his admission.

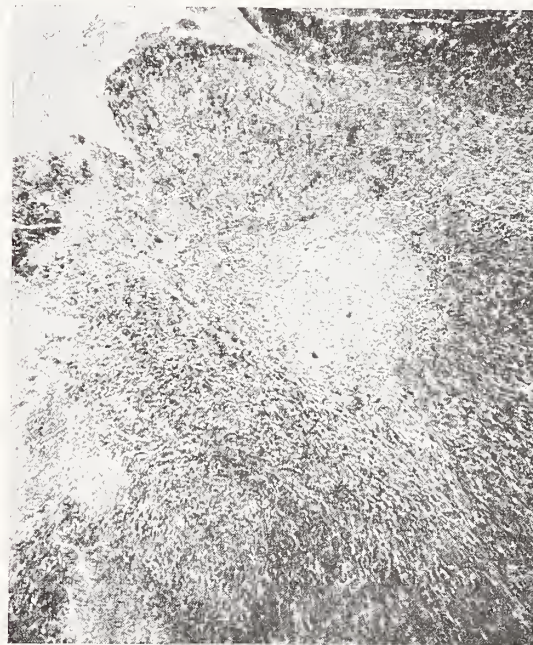


FIGURE 1

Low power view of axillary lymph node removed on 12th day of disease showing granuloma and cellular infiltration of capsule

Pathology: The initial biopsy specimen, removed from the right axilla on the twelfth day, consisted of five or six matted, enlarged lymph nodes, the largest measuring 11 × 9 × 8 mm. Microscopically (Figure 1), the capsule was thickened by fibrous tissue and infiltrated with lymphocytes and plasma cells. The lymph node architecture was altered in that the follicles were reduced in number and poorly demarcated from surrounding tissue. Germinal activity was minimal. Some sinusoids were obliterated by fibrosis and others were filled with mononuclear cells. The most striking change was the presence of a number of small granulomata (Figure 2). In some of the granulomata multinucleated giant cells were found and in one there was central necrosis. Frank caseation was conspicuously absent.

In the second specimen, obtained 15 days later from the left cervical area, fibrous thickening of the capsule was noted but no granulomata were found. Changes in the nodal architecture were similar in type to those described above but less intense. These changes are consistent with those previously described in cat scratch disease.<sup>12,13</sup>

An attempt was made to isolate the etiologic agent of cat scratch disease by means of tissue cultures\* employing monkey kidney. The value of this technique<sup>14</sup> in other viral

\*Antigen obtained through courtesy Mila E. Rindge, M.D. of Connecticut State Department of Health, Hartford.

\*Virus studies conducted by Dorothy Horstman, M.D., Sect. of Preventive Medicine, Yale University School of Medicine.





FIGURE 2

Higher power view of granuloma. Note fibrous thickening of capsule with round cell infiltration

diseases along with the apparent *in vivo* susceptibility of the monkey to cat scratch disease<sup>9</sup> lent promise to its use.

A 10 per cent saline suspension of material from the first biopsy was inoculated into ten tubes. These were examined at approximately four day intervals for twenty days. Uninoculated control tubes were followed similarly. No evidence of specific degeneration was found. Blind passage of the twenty day harvest to five monkey kidney tubes was made. No cytopathogenic effect was observed and the cultures were discarded after twelve days.

#### DISCUSSION

Since cat scratch disease may frequently simulate more serious diseases its correct recognition gains importance. In the case reported the diagnosis was obscured by the enlarged liver and spleen, the unremarkable appearance of the skin lesions and the bilateral distribution of adenopathy. The positive skin test with cat scratch disease antigen and characteristic histological appearance of the excised nodes were considered diagnostic. Other diseases were eliminated by bacteriological and serological examination.

It will be noted that the histologic picture alone is not specific.<sup>15</sup> Early in the disease these nodes show hyperplasia of the reticuloendothelial cells. This is followed by focal granulomata, often with necrotic centers, a zone of epithelioid cells and scattered giant cells. Giemsa stains usually demonstrate large basophilic inclusion bodies within reticuloendothelial cells which Mollaret et al.<sup>9</sup> considered to be of diagnostic importance. Winship,<sup>13</sup> however, has recently found similar inclusion bodies in

sections of lesions from proved cases of bacterial adenitis, tuberculosis, tularemia, lymphopathia venereum and sporotrichosis.

The normal liver biopsy specimen obtained late in the course of the disease in this case can only suggest that the changes attending the hepatomegaly were of a reversible nature.

The author wishes to thank Dr. Robert Green for his advice and encouragement in the preparation of this report.

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## MODERN VIEWS ON HEALTH PROBLEMS OF AGING

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IN OUR discussion of the health problems of the aging I shall speak from the viewpoint of a health officer and more particularly as a long time employee of an old and established health department. This means that the ideas expressed will be strongly colored by long personal and institutional experience in the control of the communicable diseases. From this point of vantage, or perhaps to speak more precisely, point of disadvantage, let us review the difficulties of reorientation from the control of communicable diseases in the younger segment of our population to that of meeting the pressing health needs of an ever enlarging group of oldsters. The New York State Department of Health and the mortality rates of New York State are used for illustrative purposes and since there is a close similarity in most pertinent respects between the situations in the adjoining states of Connecticut and New York, they should not prove too misleading.

### CHANGES IN COMPOSITION OF AMERICAN PEOPLE

The last fifty years have produced a true revolution in the age composition of the American people. The causes of this upheaval cannot be disentangled from our entire fabric of living but it is generally conceded that the two most proximate causes are the industrial revolution and the sum total of human knowledge as applied to the suppression of communicable disease. The latter is the more immediate and weighty. The golden years of biological discovery which made this suppression possible have been largely concentrated in the period which began one hundred years ago but were preceded by mankind's single most valuable discovery, Jenner's vaccination. We should never forget that to this day in the world as a whole Jenner has prevented as many deaths as the sum total of all the rest of the panoply of preventive and curative medicine, in-

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### SUMMARY

Using his experience in the New York State Department of Health and the mortality rates of New York State, the author reviews the difficulties of reorientation from the control of communicable diseases in the younger age group to that of meeting the health needs of the increasing older age group. Comparisons are drawn in the causes of death 50 years ago and at present, the health needs of the aged are outlined, and the diseases peculiar to old age are discussed. Methods of preventing chronic diseases such as cancer, alcoholism, drug addiction and the need for rehabilitation programs are emphasized. The place of the chronic disease hospital and of the nursing home must play an important part in the care of the aged in the coming years.

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cluding drugs, vaccines, antibiotics, surgical procedures, and sanitary installations.

The point in our particular culture has now been reached when the communicable diseases have been practically controlled. The one major malady which has in no wise responded is poliomyelitis. In this latter disease it seems likely we are on the very eve of success. It should not be forgotten that even now the sum of the death rate and the rate of permanent incapacity from this savage malady is less than the mortality rate from measles in 1900.

### CAUSES OF DEATH

In the year 1900 in New York State nearly fifty per cent of all deaths were due to the communicable diseases. In 1953 only five per cent could be accredited to the same causes and the percentage is still falling. This factor, together with a small contribution from the reduction in deaths due to acci-



dents, has raised the life expectancy by well over twenty years to the point where it has practically reached the biblical three score and ten. There is every indication that even without any new increments to knowledge, the rise in life expectancy will continue well into the seventies. Because of these profound changes in death rates and ages at death and since immigration has greatly diminished the percentage of aged persons is constantly rising. In New York in the year 1900 roughly five per cent of the people were over the age of 65. The corresponding figure is now nine per cent and will inevitably move upward. Despite these phenomenal changes, it is not fully descriptive to define ourselves as an aging population. This was unquestionably true during the 1930's when the birth rates were at the nadir. However, with the birth rates of the past decade, there has been achieved a very respectable balance between the very young and the old. Thus, the rate of natural increase in New York State in the year 1900 was 11 per thousand. In the year 1953 it was also 11 per thousand.

Whatever be the choice of words to describe the changing age composition, it is a fact that both the absolute numbers and the ratio of older persons are very rapidly increasing. These facts, together with the virtual conquest of the erstwhile major health problems of young people, brings us as health workers face to face with the sicknesses and disabilities of middle and old age. We can no longer defer consideration of their solution with the excuse that we have more pressing and also easier tasks at hand.

#### HEALTH NEEDS OF AGED

It is desirable to note in passing the altered and altering position of the aged in our present day civilization since health, both of the body and of the psyche, cannot be considered apart from its relation to the entire cultural pattern in which we live and have our being. In earlier phases of our development, when the rate of environmental change from one generation to the next was relatively small and when subsistence was on a marginal basis, the accumulated experience of the old was of great value in guiding their descendents along those pathways which had been found safe and more likely to guarantee subsistence. With the development of the printing press, the experience and lore of the old immediately suffered a substantial loss of prestige. With the onrushing of the industrial revolution

bringing the movement away from the soil and the ever increasing tempo of technical development, the wisdom of old age became progressively less important as compared with resiliency of mind and ability to adapt to new and changing conditions. These tendencies, together with continued urbanization with its less commodious rooming, have resulted in a continued degradation of the dignity of old age and of the esteem in which it is held. The momentum of these ideas was carried to extreme in industry and only during the last war was there a general reorientation of our thinking to recognize anew the need for utilizing the skill and dependability of the older worker. It is now being perceived increasingly that it is possible for the aged to make a real contribution to modern life. It is also becoming apparent that, even with our vaunted ability to produce, society needs the productive capacity of the old. Furthermore, from a human standpoint, it is crystal clear that there exists a deep seated and inherent necessity within the individual himself to remain useful and productive. Both society and the aged themselves are best served if they are kept at gainful occupation so long as they have the physical and mental capacity to make a worthwhile contribution. We are recognizing that Stevenson's lines "to travel hopefully is better than to arrive, and the true success is to labor" applies also to the twilight of life. It is against this general background that we consider the modern views on the health needs of the aged and how best to meet these needs. In general, these views can be summarized in two general statements: (1) old age is not a disease in itself and (2) the disabilities of old age are in large part due to chronic illnesses, many of which have their origins in early or middle life. It is desirable to repeat that old age is not intrinsically a disease nor is it of necessity a disability except at the very end of the life span. Many persons age without discomfort or without serious physical disability except for a slow diminution of muscular power and slowing of reaction time. Many aged maintain full or close to full mental capacity until well into the ninth decade. This is significant and should underlie much of our thinking. Throughout medical research the starting point in the solution of many problems has been the demonstration that differences exist, that if certain persons escape disease or disability it should be possible to find out why they escape and undertake the necessary changes to assure that others are steered clear from hazard.

It follows then that the greatest single need is for research. It also follows that the prevention or amelioration of chronic diseases by whatever steps can be devised is the proper approach to the solution of the maladies of the aged. It is further apparent that in many instances prevention must begin early in life.

#### DISEASES OF AGED

The more important afflictions which must be attacked to improve the health of the aged are: cardiovascular diseases, cancer, senile psychoses, arthritis, accidents, diabetes, and tuberculosis. Diseases of the heart and blood vessels are the first health problems of the day. Even in this field there are areas of progress. Deaths from rheumatic heart disease at all ages, from childhood into old age, have been and are being greatly reduced. Bacterial endocarditis is correspondingly falling and these two will decline further as the age phalanx in which rheumatic fever has been minimized moves into old age. Syphilitic heart disease which formerly took large numbers of persons in middle life and beyond has essentially vanished from the American scene. Coronary heart disease, based on arteriosclerosis, is another story. This entity apparently has increased within the past few decades and is now the single biggest killer among persons in middle life and old age. It occurs four times as commonly among men as among women. This is not one of those differentials that gives us great hope for immediate success since the fundamental differences between men and women are not susceptible of easy manipulation, and there is a question of the desirability of any attempts along this line, but it does suggest lines of investigation. Moreover, the fact that many persons achieve old age without evidence of arteriosclerosis, be they men or women, does give hope of discovering information as to why some escape. Of even greater portent is the circumstance that deaths from heart disease, and more particularly from coronary heart disease, are very much more frequent among certain nationals than amongst others. It appears to be clearly established that American men are the most unhealthy in the world with respect to coronary heart disease. The reasons for this are being actively investigated and at the present time suspicion centers upon the high fat content of the American diet as being the culprit. Should this lead be substantiated, there is very real possibility of adding several years to life expectancy and of preventing untold years of incapacitation.

The next cause of cardiovascular disability, hypertension, offers less immediate hope, although research is pushing forward on numerous fronts and a number of drugs are under evaluation at the present time as to their ability to reduce symptoms or ameliorate or delay damage.

There are several service programs which can be of great value in the field of heart disease, particularly those designed toward the rehabilitation of persons suffering from heart disease and more particularly the rehabilitation of persons who have suffered from apoplexy. It is also apparent that nutrition, even in our present deficient state of knowledge, has a key part to play in prevention and rehabilitation. The prevention of obesity in itself would do much to delay the onset of heart disease and to aid in the rehabilitation of those afflicted.

Cancer is now the second cause of death. With one exception, there has been no great increase of this group of afflictions when correction is made for the age factor. Among women it appears that there may have been a small decrease in recent years in the incidence of cancer. The outstanding exception is cancer of the lung in which the mortality rate among men is five times and among women twice as great as it was two decades ago. Recent research has demonstrated beyond question of doubt that the largest single factor in the causation of lung cancer is cigarette smoking and it now appears that cigarettes are killing more people than tuberculosis. This, of course, suggests the taking of steps for prevention of this special type of cancer but the social forces being what they are, it is not apparent immediately how to take advantage of this knowledge. Research in cancer is pushing ahead in many fields. The practical results are not overwhelming at the moment, but there is strong reason for hope and every reason for intensifying investigative programs.

From a practical standpoint there is much to be done in cancer which is presently imperfectly executed. It is estimated that only one person in four who acquires cancer is being cured despite the statement that cancer is curable if discovered early enough. This latter is true only in part. With present day development of therapy and relying upon methods of detection which are practical, it is guessed that under the best of conditions one cancer case in two can be cured. Since approximately one person in four now living can expect to develop cancer at some time during life, it is apparent that the saving in life which can be effectuated by the



more vigorous application of our existing knowledge and social organization offers tremendous possibilities for life saving.

Diabetes is a disease in which the therapeutic advances initiated by Banting and Best have made it possible to maintain persons in a state of near normal health for many years. Nevertheless, present day treatment does leave much to be desired and in many patients arteriosclerotic processes progress. Furthermore, no absolute method of prevention has yet been devised although the obese are known to be much more likely to develop diabetes than those of normal weight. The disease is one of the hazards of middle life and old age and calls for a more intensive attack on obesity together with programs of early case finding so that lives can be prolonged through the prompt institution of proper therapy.

Accidents remain as a largely unsolved problem affecting all ages. Their disastrous affects are felt most heavily on the male sex in the early and middle years of life. In the declining years accidents are equally important among women and are one of the most serious problems of the senium. It is necessary to bear in mind, however, that the picture with regard to accidents has improved greatly in the last fifty years and that mortality rates from accidents are roughly half of what they were at the beginning of the century. As is the case with most other causes of death and disability there is an impelling need for intensified research. This could be most fruitful with regard to automobile accidents. Further knowledge is needed with regard to the quirks of human nature which are the bases of most vehicular accidents. Recent studies also indicate that great saving of life could be accomplished through improved auto construction. It is further apparent that improved design of housing for the aged offers real advantages. In the salvaging of those persons who have undergone severe trauma from accidents, much can be offered by modern rehabilitation techniques.

Arthritis in the aged rarely kills but is the greatest single cause of disability. Definite advances have been made in the treatment of arthritis during recent years but remedial care remains imperfect and calls for continuing investigative efforts. In the treatment of this disease, intensive application of known methods of therapy and more opportunities for rehabilitation are needed.

The senile psychoses constitute a group which is one of the greatest contributors to unhappiness in old

age and to the inability of offspring to keep parents in their homes as an integral part of the family. These psychoses are highly associated with arteriosclerosis and it is to be hoped that research, looking toward the delay or prevention of onset of arterial degeneration, will make an immense contribution toward the solution of the dementias of old age. Since not all of the mental illnesses of the old are based on arteriosclerotic changes in the cerebral vessels, the entire situation needs greatly expanded research into causation before there can be any confident talk about prevention. The changing social structure, with a shift from rural to urban living, with smaller housing units, and the continued development of apartment housing, has made the problem of senile psychoses more acute than it would be otherwise. Under rural conditions very gross deviations from the normal could be tolerated in older people without too great a burden on the family or without exciting neighbors. In modern apartment housing or even under conditions of suburban living it becomes speedily necessary to seek institutionalization for the mental aberrations of old age.

Tuberculosis has fallen from the number one position as cause of death in 1900 to relative insignificance, the respective rates for New York State being from 217 per 100,000 to 14. In some of the rural counties the rates are already approaching zero. Nevertheless, because of the prolonged disability induced by this disease and its infectious nature, it remains an important health problem and one cannot yet confidently predict its early extinction. The newer drugs which encourage home treatment may recreate old difficulties of having patients with positive sputum spreading the infection among home contacts. Tuberculosis is now predominantly a disease of middle aged and old men and so continues of interest in the field of geriatrics. It seems probable, however, that a continued diligence in the application of existing methods of early discovery and prompt treatment will result in a persisting decline in the importance of tuberculosis.

#### HOW PREVENT CHRONIC DISEASE

Having outlined briefly the more obvious problems in maintaining the health of our aged, I should like to mention some of the steps that are currently being taken among the official agencies in New York State to reorient our health programs toward chronic disease prevention. For some years now the legislative committee known as the Desmond Committee has been carefully studying the situation in

New York State with regard to the aging process. This Committee has been interested in the entire picture including economics, recreation, education, health and welfare and has made sound and constructive suggestions in each of these fields. It has also served and is serving to alert the public as to the need for thought and action.

As already noted, the most pressing need in geriatrics from the point of view of all health agencies, official and unofficial, is for research in the field of chronic disease. For this purpose the New York State Department of Health has recently established a cardiovascular health center in cooperation with the Albany Medical College. This is basically a long term study of 2,000 male state employees in the age group 40 to 55. The first investigation undertaken in this center is to test the predictive value of present day tools in the discovery of early coronary heart disease and as time and personnel permit it is intended to superadd other studies looking toward information on the etiological factors in heart disease.

The New York State Department has maintained a small cancer research hospital for many years. This is currently being expanded from 100 to over 500 beds and at the same time the research staff itself is being multiplied greatly in excess of the increase in beds. This expansion will be completed within the year and we hope to be in the van of cancer research. The hospital will also provide medical care but only incident to its research program. Members of the staff of our research hospital, together with the operating staff of the Bureau of Cancer Control, were among the first groups to study the relationship of cancer of the lung to cigarette smoking. Studies on this subject as well as in many other fields are being pushed with renewed vigor.

Four years ago the Department, together with the University of Buffalo, established a Chronic Disease Research Institute in which research on various aspects of chronic disease is being pursued. Already significant contributions have been made in Wilson's disease, or hepatolenticular degeneration, in the development of perfusion apparatus and in the rehabilitation of the hemiplegic.

For some years our Department has maintained tuberculosis hospitals. At the present time these are seven in number, with a capacity of somewhat over 2,000. Research programs are being conducted in each of these hospitals.

In our Division of Laboratories and Research there is a long tradition of original investigation into the various aspects of communicable disease control. Within the last year in this Division we have opened a blood protein laboratory for research into this newer field and we are contemplating a corresponding reduction in research on and production of biological products for the control of communicable diseases.

As a further evidence of shift within the Department, the Bureau of Epidemiology and Communicable Diseases has recently completed two pilot studies on auto driver behavior using the epidemiologic method. It is expected that studies on this subject will be continued. Another study being carried on in which our Department acts only in an advisory capacity is a long term investigation by the Mental Health Commission of which the Commissioner of Health is a member. This study, taking place in the city of Syracuse, is concerned with the prevalence of the senile psychoses and is utilizing the epidemiological method in attempts to associate the incidence of these psychoses with a number of factors in the individual's environment.

A very significant study by the Department in the non communicable disease field is nearing completion. This is the Newburgh-Kingston study on the effect of fluorinating public water supplies to prevent dental caries. The results have fully validated the conclusions drawn from areas where waters are high in natural fluorine content and are leading to practical application. Although one thinks of dental caries prevention as primarily for children's welfare, it is only partly true. Children and young adults can enjoy vigorous health with very poor masticating equipment, but the aged have much greater need of the chewing ability.

The actual services being provided by our Department for chronic disease control are relatively fewer than are the research programs which is as it should be in the present state of development. The largest service program is in tuberculosis which serves as a sort of bridge between the conventional communicable disease programs and the several for chronic disease.

The Department is subsidizing 17 cancer detection centers and 28 tumor clinics throughout the State. The cancer detection centers have already shown year after year that, although early cancer is found in less than one per cent of the adults examined,



other significant chronic diseases requiring medical care are discovered in from one-third to one-half of those examined.

A Bureau of Cancer Control has been maintained for many years which is responsible for securing reports of cancer cases and, together with the cancer research hospital, carries on investigations into different phases of cancer control. The Bureau also conducts a program of public and professional education. The Division of Laboratories and Research together with state aided laboratories provide tissue and smear diagnostic services.

The Department has been conducting mass x-ray chest surveys for some years now and a total of well over 1,000,000 pictures have been read. Within the past year this program has been expanded to include a definite effort to discover chest tumors and to follow up through the appropriate agencies so as to encourage complete diagnosis and therapy. This procedure is also being expanded so as to attempt to determine the incidence of cardiac abnormalities. For every two cases of probable active tuberculosis found on this survey, three cases of probable lung tumor have been found of which more than ten per cent turn out to be malignant. Since 1947 the Department has subsidized a program to provide free chest x-ray to all adult patients admitted to general hospitals. Over one million have been x-rayed. This is one of the most fruitful ways of discovering previously unknown cases of tuberculosis, lung tumors and heart conditions, the yield being about twice as great as in the mass chest x-ray surveys.

Multiphasic screening services so far have been developed poorly in our State. This appears like the next step and it is intended to establish such a screening clinic in conjunction with the Chronic Disease Research Institute in Buffalo. In several local areas health departments are, with state aid, conducting tests for the detection of diabetes.

An alcohol treatment center has been subsidized by the Health Department in one area of the State and more recently other centers are being established with subsidies from the Mental Health Commission.

A center for the treatment of adolescent narcotic addicts was initiated in New York City with State aid.

Within the last year in New York City the local Department of Hospitals has opened a 2,000 bed chronic disease hospital.

A small pilot study for the rehabilitation of mus-

cular dystrophy is being conducted at the State Health Department's rehabilitation hospital at West Haverstraw.

One of the important programs of the Department has been the medical rehabilitation program for persons under the age of twenty-one and for adults with poliomyelitis. Under this plan, State aid of fifty per cent is offered to counties and cities for the correction of any remediable defects in children such as extensive burns, orthopedic deformities, cardiac surgery, orthodontic abnormalities and others. Recently this has been expanded to include the purchase of hearing aids for deaf children. Although this is directed towards the early years of life, it is nevertheless essentially a chronic disease program and eventually is contributory to minimizing problems of old age.

A 200 bed rehabilitation hospital at West Haverstraw has been maintained for many years. This is devoted primarily to the medical rehabilitation of children although a certain number of adults are given treatment for polio.

Another service offered by our Department is in postgraduate education for practicing physicians in the field of cancer control and heart disease.

Since 1951 our Department has actively promoted the fluorination of public water supplies and at the present time 24 communities with 800,000 population in New York State are so treating their supplies. Twelve additional places with a million population are about to fluorinate.

Earlier this year our Department established a Bureau of Chronic Disease and Geriatrics and appointed a director to guide and coordinate the programs in this field.

The State Department of Social Welfare is responsible for the medical treatment of the indigent in New York State. Relatively little preventive service has been available until recently. However, under the new program of subsidization by the federal government of aid to the permanently disabled, a strong effort is being made to direct the services toward prevention and rehabilitation.

The commissioners of the various state departments which provide direct service to the people constitute the Interdepartmental Health Council of which the Commissioner of Health is chairman. This group meets once a month to discuss the coordination of interdepartmental programs. A subcommittee of the group is currently devoting inten-

sive attention to the question of rehabilitation services available in the State and will make recommendations as to needs.

I have outlined some of the research programs and the services being currently supplied. It is apparent that these are not comprehensive nor do they indicate a complete reorientation from communicable disease control to chronic disease control. The realignment must occur gradually and its extent will be determined by many factors. Final decisions will, of course, be made by the public through the Legislature but in the interim continuing consultations and discussions among the voluntary health agencies, the official agencies, and the medical profession are needed so as to delineate the functions of each and determine the most effective and useful methods whereby the health needs of the aging can be met.

#### THE FUTURE IN MEDICAL CARE OF AGED

Some of the decisions which must be made are the following:

The New York State Health Department operates seven hospitals with a total capacity of approximately 2,000 beds. More than that number of beds are also available in municipal institutions. According to present trends in the death rates from tuberculosis and occupancy rates, within a decade these institutions will be only partially utilized. Should they eventually be abandoned or should they be used in combatting other diseases such as lung cancer which is increasing at a faster rate than tuberculosis is decreasing? Additionally, should they be used as rehabilitation facilities whereby older citizens suffering from chronic diseases could be given highly specialized physical therapy treatment and instruction and either fitted for return to self care or to gainful employment? There is a strong body of opinion that the problem of rehabilitation is one that will require governmental subsidization in order to make advances in modern physical medicine available to all of our citizens who require such specialized care. Should this be done through additions to existing general hospitals or through the construction of chronic disease hospitals in each of our medical centers?

How shall we provide adequate institutional and home care for chronic disease patients? There appears to be crystallization of opinion that opportunities for home care such as had been demonstrated in the Montefiore hospital will be urgently required and that such a program offers an opportunity for

human salvage at a reduced cost. The place of nursing homes in the care of the chronically ill needs to be redefined and minimum standards established for their conduct.

The recent amendments to the Hill-Burton Act are designed to encourage the development of nursing homes and rehabilitation centers. This expression of interest on the part of the federal government should assist the various States in arriving at decisions as to the proper utilization of these facilities.

How shall we detect chronic disease early enough and in enough people? Aside from research the greatest single public health aspect of chronic disease lies in early case finding. It is obvious that mass screening techniques need careful study and refinement. It appears almost certain that only by mechanical screening procedures, utilizing technical rather than highly trained professional personnel, can early case finding be both productive and economical. Unquestionably there needs to be much further effort put into the problem of periodic physical examinations by the practicing physicians in their offices. Efforts in this field have been relatively ineffective to date and it would seem this cannot be the full answer to early case finding. This is clearly so when one considers the number of hours that would be required by physicians to perform annual or even biennial examinations. There are not enough physicians in the communities to carry on such a program.

How shall we further extend the availability of home nursing care by our public health nursing system? Year by year public health nurses are being forced to devote a higher and higher proportion of time to actual bedside care. This is dictated by the constantly increasing incidence of chronic disease. There is a need for re-evaluation of public health nursing and an exploration of the value of auxiliary personnel to assist the public health nurses in giving bedside care.

It must be reiterated that in all these problems of the future we must have the joint thinking of and substantial agreement from all of the interested groups in the community. Decision, however, cannot be deferred into the far future since we are truly at the crossroads in the sphere of public health. We have almost explosively reached a stage in which the need for communicable disease control has vanished except for the requirement of continuing preventive measures, and at the same time we are faced with a steadily burgeoning of chronic disease.



Which services are to be provided by public agencies and which by private agencies is an important decision, but it is even more vital that chronic disease be vigorously attacked with all our resources. If we press forward on all fronts, much can be done to postpone into extreme old age that state which is described more vividly in Ecclesiastes than anywhere in current literature.

"Remember now thy Creator in the days of thy youth, while the evil days come not, nor the years draw nigh, when thou shalt say, I have no pleasure in them;

"While the sun, or the light, or the moon, or the stars, be not darkened, nor the clouds return after the rain:

"In the day when the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders

cease because they are few, and those that look out of the windows be darkened,

"And the doors shall be shut in the streets, when the sound of the grinding is low, and he shall rise up at the voice of the bird, and all the daughters of music shall be brought low;

"Also when they shall be afraid of that which is high, and fears shall be in the way, and the almond tree shall flourish, and the grasshopper shall be a burden, and desire shall fail: because man goeth to his long home, and the mourners go about the streets:

"Or ever the silver cord be loosed, or the golden bowl be broken, or the pitcher be broken at the fountain, or the wheel broken at the cistern.

"Then shall the dust return to the earth as it was: and the spirit shall return unto God who gave it."

## DOCTOR AND HOSPITAL

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A CENTURY ago hospitals for the most part were almshouses. With the development of modern surgery and improved methods of diagnosis the hospital has become necessary for rich and poor alike. The obvious need for more and better facilities in a time of unprecedented post war prosperity has resulted in the building of many additions to old facilities and the construction of new hospitals in places which had inadequate hospitals or no hospital at all. As the result of this expansion there has been considerable confusion among doctors, nurses, and people in administration in adapting their activities to changed conditions. It is one thing to have a fine physical plant. It is another to have an efficient, capable, spirited organization dedicated to the task of sympathetically caring for the sick and the suffering, properly training young doctors and nurses, and providing the opportunity to advance our knowledge through research. With the changing order the relationship of the doctor to the hospital presents new difficulties and problems in maintaining the old relationships that are good and achieving success in establishing the new.

### THE PATIENT

The care of the patient now as always should come first. The patient turns to the doctor for help,

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### SUMMARY

The relationship of the physician to the hospital is discussed. The proper function of the medical staff is outlined. Medical decisions belong to the staff, administrative decisions to the administration. Harmony between the two is a *sine qua non*. The lack of good bedside nursing is deplored. The profession of nursing should be made more popular. A solution should be found to obviate long periods of waiting before patients can be admitted to hospitals even to increasing the number of patients cared for at home. The house staff should be more adequately compensated.

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and he in turn admits the patient to the hospital for study and treatment. In order to give this patient the best of care, the doctor must have the help of the nursing service and the hospital administration. This is the natural sequence of events. With the growth of our modern hospitals, some becoming very large institutions, it is not uncommon to find the administration assuming a leading role, the nurs-

ing service an independent attitude, and the doctor and patient becoming customers who are admitted if they are lucky enough to get in, getting along the best they can with whatever facilities are available. Nothing is more frustrating for a doctor nor more unsatisfactory for a patient. Often the organization loses its spirit and the patient becomes unhappy. As a result, the work and reputation of the institution deteriorates. There is only one satisfactory chain of command; it is the one that follows the normal demands in the treatment of a patient.

#### ADMINISTRATION AND MEDICAL STAFF

The medical staff of a hospital should not relinquish its prerogatives in maintaining the proper standards of medical care. Most hospitals have a board of directors with an executive committee and a director who carry on the business side of running a hospital. The directors are usually men who have the community welfare at heart; they are leaders in their respective fields of endeavor, and they are endowed with a desire to make a voluntary contribution to the welfare of society. Many take a great interest in the hospital, spending long hours carrying the burdens which fall upon their shoulders. They are to be admired and should be honored for their labors. However, it is a natural thing for a banker to want to run a hospital in the same way he would run a bank; an industrialist in the same way he would run his industry; a utility executive in the same way he would run his utility. A hospital is entirely different. The final decisions in business are made at the president's office; in medicine the final decisions are made at the bedside. It is not unusual to find the executive committee of the board of directors and director with honest desire to do the right thing and realizing their moral and legal responsibilities to provide the best possible medical service overlooking this one fact. Unable to make the medical decisions themselves, they naturally turn to someone in medicine who is a good doctor and a gentleman, but unfortunately is frequently someone who is naturally unwilling to sacrifice his own personal popularity to fight aggressively for any pressing medical need. Conformity or fear of the consequences which has infiltrated our American thinking since the war finds fertile soil here in which to flourish. Independent thinking, speech and action, the philosophy of the past which made our Republic great borders on impropriety. The best solution can only be found in mutual trust, and a staff which cannot be trusted should cease to exist. Obviously in

a democratic society the staff should be given enough freedom and confidence to organize so that the work of its officers nominated or elected and its standing committees can lead the way in guiding the resolution of practical problems of medical care and maintaining the proper standards of practice. A staff quietly phagocytyzed by a hospital administration only produces a paralysis of action and an apathy of thought. Equanimity is difficult in spite of soothing words when a doctor becomes aware that it is his patient who suffers and that he can't do anything about it. It is important that the organization of a hospital be maintained with the proper balance of authority between the directors and the medical staff. The administration should not dominate the medical staff. Both should have their duties to perform and be integrated so that they function efficiently and effectively with trust in each other for the best interests of the patient.

In a recent paper a distinguished layman on one of our hospital boards states that in the selection of chiefs of staff by the directors "those whose judgment has been found to be the calmest, the most objective, the most unbiased, the most disinterested are the weightiest." These characteristics are of course what any hospital administration likes and if the doctors have no problems will suffice. However, in time of need they form an obstruction to action, and in periods of development a deterrent to progress. Why not men of imagination, courage, and ability to recognize needs and do something about them; people with interest and enthusiasm; people who have ideas and are willing to express them; people who are dynamic rather than static? No ship ever sailed a sea in a dead calm. No institution ever became great without people with a burning desire for service and achievement. Calmness and disinterest only lead to stagnation. In the last half century, the greatness of the Mayo Clinic was due to the vision and industry of the Doctors Mayo; the fame of the Harvard Medical School and Peter Bent Brigham Hospital was due to the genius of Harvey Cushing and his contemporaries; the distinction that came to the Johns Hopkins was due to the character and the work of the Johns Hopkins doctors. A beautiful building is highly desirable, but the character and work of the people therein determines the real value of the institution.

#### NURSING CARE

Another problem which confronts the doctor today is the want of good nursing care for his patients.



The time is ripe for the nursing profession to return to the bedside. In my experience twenty-five years ago the care of the sick was nursing's primary objective. At about that time nursing took off and soared into the fields of higher education. In some instances the regular training school was abolished. I think that it was the original intent to have a better nurse at the bedside as the result of better preparation and if this idea had been carried out we would be better off. One would think that the more higher education a person had the more understanding, the more practical, the more efficient, the more human that person would become, but unfortunately, one finds all too frequently an academic aloofness and conceit, lack of practical understanding, and a departure from nursing's primary objective—the intelligent and sympathetic care of sick people. Actually these girls have gone into hospital administration, public health, and special forms of nursing with the result that instead of the trained nurse at the bedside we find substitute groups such as attendants, aides, and practical nurses. They are more and more being given the responsibilities of the trained nurse, but have not had the preparation given the product of our nursing schools.

Nurses have taken flight from the bedside because of opportunities in industry, the armed services, and business establishments attracted by easier work, shorter hours, and higher wages. In my experience they are frequently wasted in these positions, doing work that could be well done by a medical secretary with a little knowledge of first aid.

A short time ago I attended a meeting on nursing when eight different categories of people were presented as illustrative of the different groups in nursing or cooperating in nursing today. Three of these programs were sound, the remainder obviously inadequate for good bedside care. At about the same time one of our nationally known figures in public health told me that he thought the attendant and allied groups were the answer to bedside nursing. To me nothing could be more tragic.

At the present time it is hoped that the nursing profession will clarify the objectives of nursing education. There are a number of different fields which require distinct types of preparation and the educational program should be planned to adequately cover these needs. Roughly this should include a training school program, a collegiate program and a graduate school program so integrated that a student

may take all or a part of the work depending on what she plans to do. It would be well if more of the cultural studies could be carried with the practical. In the same way that the liberal arts are so important in the preparatory education for the other professions, nursing would do well to include similar studies in its program. However, in all this planning the main objective should remain the intelligent and sympathetic care of the sick, and bedside nursing should not be allowed to slide into the hands of incompetent and inadequately trained people.

It is also time to make nursing popular, and if it takes shorter hours, higher wages, pension plans and other concessions to do it, why not provide them? In terms of cost of many nonessential things the American public pays very little for its medical care. Were the expense spread over a lifetime instead of at the time of illness the amount would not be impressive. Our voluntary insurance plans have attempted to accomplish this in part. In time it is hoped that we may find a way of providing more complete coverage in a way satisfactory to doctors, nurses, and patient alike.

#### THE PROCESS OF ADMISSION

Another problem in the relationship of the doctor and the hospital is the difficulty in prompt admission of patients to the hospital. A few places are fortunate in having no difficulty in this respect, but a good number are forced to have a long waiting list with delay up to two to three months before a patient can be served. This condition is blamed on the shortage of nurses, a lack of beds, or a few other etiological conditions, but in my experience until the beginning of the Blue Cross and other similar insurance plans we had no problem. It is very obvious that many people are being admitted to our hospitals who were formerly cared for in the home and could be cared for in the home today. Surgery demands hospital service. A few other categories of medical care also demand hospital service. One of the most helpful things that could be done would be to give those cases that demand hospital care a priority or refuse hospital care altogether for those that could be taken care of elsewhere until this difficulty has been relieved. This problem should be made the responsibility of the doctors and not of the administration, and the doctors should be given the freedom to accomplish it. I am confident that the present difficult situation in some areas would be eased considerably if this were done.

## COST OF MEDICAL EDUCATION

Finally, the economic status of the house staff has been and remains an unreasonable and unjustifiable condition. Originally medical education and hospital training were limited to a few years, but as time has gone on after four years of medical school anywhere from four to eight years of medical experience is required in order to qualify for the different specialties. Recently military service has been added so that a man may be in his early thirties before he is able to become financially independent. It is a normal thing for a man during this period to be married and start his family life. Nowhere in any walk of life does society expect so much for so little. The service rendered is not compensated for by training. All over our nation young men are servicing our hospitals with little or no compensation. It is obviously unfair and unreasonable. Where is this added expense to come from? The answer is the consumer, and I believe it could be accomplished in the same way that has been discussed under nursing. Can the consumer pay? Last winter I bought a new refrigerator. It cost \$529. The salesman called to my attention that I had done an appendectomy on his wife. Upon returning to my office I noted that I had

charged him \$125 for the appendectomy. Having been told that a salesman's commission on a refrigerator was 25 per cent it occurred to me that his commission was \$132 or slightly more than my charge for an appendectomy. The other day a patient came into my office and said that \$200 was an excessive charge for a radical mastectomy for cancer performed on his wife, yet when he left the office he departed in a new automobile that cost at least \$2,000, which at present is a minimum price for a car. Is a life worth ten per cent of the cost of a car? I think it is and I think that the people of this country have the capacity to pay their way, if the method is practicable and they understand the problem.

These are a few of the difficulties confronting the doctors in their relationship with the hospital today. There are many others. In the last half century our progress has been rapid and our achievements many and great. It is hoped that as the future unfolds our difficulties will be resolved for the mutual welfare of our American people and the medical profession, traditionally and currently the unselfish guardians of the health and welfare of our nation.



# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### Christmas

"Ah, friends, dear friends, as years go on  
and heads get gray,  
how fast the guests do go!

Touch hands, touch hands, with  
those that stay.

Strong hands to weak, old hands to young,  
around the Christmas board, touch hands.

The false forget, the foe forgive, for every  
guest will go and every fire burn  
low and cabin empty stand.

Forget, forgive, for who may say that  
Christmas day may ever come  
to host or guest again!

Touch hands!"\*

The Christmas season brings to us all the opportunity again to touch hands. What a privilege! In our busy lives what better way can we find to express our friendship and respect for each other? And let us not forget our patients also at this Christmas season.

"My best wishes for your Merry Christmas and your happy New Years, your long lives and your true prosperities. Worth twenty pound good if they are delivered as I send them. Remember! Here's a final prescription added, 'To be taken for life'."†

### Hartford Hospital, We Salute Thee!

The year 1954 has been noteworthy for the celebration of the Centennial of the Hartford Hospital.

As the curtain falls at the end of this month, those who planned the various events may look back with pride and satisfaction. Exhibits, demonstrations, historical articles in the press, participation in the annual meeting program of the State Medical Society, a special corporators dinner, a ball at the new Statler, distribution of a Centennial Souvenir Booklet, and finally participation in the Regional Meeting of the American College of Physicians—all these and many more activities have continually reminded the medical profession and the public of the accomplishments of unselfish men and women over an entire century.

Recently one of our South American neighbors spent several months in Hartford. His impressions of the Hartford Hospital as expressed in a letter to the press are worthy of more than a passing glance. We quote:

"If I wanted to show a foreigner how the American people are, Hartford Hospital alone tells the whole story. Never before have I seen such an amazing display of teamwork and organization. From housekeeping to administration, everything is perfection up to its details. The whole is a self-sufficient organization supplying sick people with all modern advantages. House cleaners, male and nurse aides, nurses, residents and doctors on one hand and office clerks and managers on the other, offer the patients a full range of comforts and attention. . . .

"It is in the hands of these wonderful people, tireless and always aware that the job has to be

\*Murray's *John Norton's Vagabond*

†Lear's *Doctor Marigold*

done, that rests the destiny of the free world. It is the sentiment of you Americans, to work eternally for a better world to live in. . . . You represent the Statute of Liberty and Freedom, and if you must suffer the weight and burden of having to wait a generation to be justly appraised by your attackers, don't forget that it is for the great only to give and not receive anything in return."

Reviewing the events of the Centennial there is included in this issue some of the highlights of the year. The remarks of the departing director, Dr. Wilmar M. Allen, are here. Also the new director, Dr. T. Stewart Hamilton's prophecy for the next one hundred years. Previous histories of the Hartford Hospital have given emphasis to events as much as to individuals. The paper prepared for the Hospital's share of the State Medical Society's annual meeting and included in *The Historian's Note Book* attempts to recall the personalities of those physicians who made the Hospital great. Finally, Robert Goodell, one of Hartford Hospital's former interns and now a leader in medical insurance circles, adds a touch of humor to the scene, a fitting close to our recognition of all that great institution has meant to the profession and to the community which it serves.

### Who Are Surgeons?

Surgery is not an exact science necessarily but it is a very exacting science. Surgeons have grave responsibilities and these responsibilities can be met only with eternal vigilance, dedicated principles and careful work.

The Bulletin of the Joint Commission on Accreditation of Hospitals asks, "Who May Do Surgery" and then goes on to answer the question.

"Good surgery cannot be measured blindly by years of residency, preceptorship or number of operations assisted at or performed. Certain individuals, no matter how long or where their training, will never become good surgeons."

"Formal resident training, College of Surgeons Fellowship or Board Certification are all excellent criteria and a physician desiring to do surgery should be encouraged to set them as his goals. Recognition of the worthwhileness of the above criteria cannot be overemphasized and they should stand high in all staff evaluations. The frank, brutal truth remains, however, that they sometimes, though not often, are only a piece of paper; that time can warp

a man's judgment and poor health can slow the facilities of a surgeon's hands until he becomes a dangerous man in the operating room."

"Merit alone is the only criterion for judging physicians' surgical abilities. This judgment should be performed by those capable of judging other qualified surgeons, by those who are willing to accept the responsibility and to attest to the public and community that 'in our judgment this man is capable of doing good surgery'."

"In our present medical set-up this means that a staff surgeon should be judged by those other members of the staff who have seen him work, use his judgment and exercise his ability. It becomes a local personal equation in every hospital. It is a terrific responsibility. It can never be decided on a friendship, personality or class basis."

### The Satisfactions of Senility

*Many men, many minds.*

OLD ADAGE

One of the presenting problems of old age lies in keeping retired workers in a contented frame of mind and, like all other problems connected with the ageing process, it is going to be increasingly important, for the proportion of old people in the population is steadily rising and the number of oldsters retired from their regular jobs and supported by public or private retirement funds, sometimes inadequate, is likewise on the upgrade. Then there are those who voluntarily retire because of long and exhausting service or ill health, and a small proportion of the population who have never worked because, for financial reasons, they didn't need to, and have spent their lives fighting off boredom by methods which are usually themselves boring.

The mass of the retired is, of course, a very heterogeneous one, it contains "many men of many minds": craftsmen accustomed to manual labor, office workers, teachers, salespeople, farmers, politicians, professional men, and a host of folks engaged in the varied and multifarious occupations of modern life. Under living conditions in these United States most of these can at least read, write, and cypher, and the more intelligent and ambitious among them are capable of rising above the mass and may even achieve great things. It is perhaps not remarkable that in this group there should be a good many who seem void of interests outside their regular work, and one wonders how much this is



due to innate and perhaps hereditary qualities and how much to lack of opportunity or training. One can realize too that some occupations are so exhausting that the resulting inertia suppresses the incentive and energy to develop outside interests. Then too the question of habit comes in, for man is essentially a creature of habits, good and bad. When one considers the extraordinary diversity of interesting avocations which exist under the conditions of modern life, one cannot help wondering why everyone has not some fad or fancy outside of their regular work which intrigues them. Is some stimulus lacking in our system of education, or is the fault an individual lack of imagination or innate curiosity?

The problem is partly an economic one, for some old people are retired with insufficient means and need wise counseling in order to get new jobs. Luckily there are, in some places, Old Age Counseling Centers, which have tackled the problem wisely and scientifically, but there is need for many more of them. But this is only part of the picture. Many old folks need contentment rather than cash. An empty life is not a happy life for one who has been accustomed to work. Much more publicity should be given in the lay press and over the radio to the desirability of preparation for retirement than the subject has so far received, and it should be emphasized that this preparation should be begun years before retirement is expected and should not be put off until the last moment. The medical profession should add this item to their program of professional counseling. They might comment also that many retirement plans which fix a specified calendar age are not based on realistic facts. It is common knowledge that some men are senile at 60, or at least show the physical and mental attributes of old age, while others are physically active and mentally alert at 75 or even older. There should be more elasticity in retirement plans.

G. B.

### The House of Delegates

On Thursday, December 9, the State Medical Society House of Delegates will convene in New Haven. Two principal matters of business are on the agenda: (1) changes in by-laws; (2) the 1955 budget.

The by-law changes consist in brief in making the alternate councilors regular members of the Council, thereby extending to each one of them a vote. This will replace the former two vote privilege

enjoyed by the councilors from the eight County Associations and reduce the vote of each one of the latter to one. In addition the new by-laws will make the speaker and vice speaker of the House members of the Council, each with a vote.

The budget for 1955 calls for an increase in certain items necessary for the Society properly to fulfill its functions. Noteworthy among these increases are the allotment for the American Medical Education campaign and the operation of the Public Relations department of the Society. The need for a greater interest by our members in the American Medical Education Foundation is obvious to anyone who is cognizant of the predicament in which our medical schools find themselves. As for our Public Relations program, Dr. Thomas P. Murdock of Meriden has stated it very clearly when he said that it is one of the best investments we can make in placing before the public the real position of American Medicine.

Be sure your delegates attend.

### Thefts of Physicians' Bags for Narcotics

Physicians are warned about the sudden upsurge of thefts of physicians' bags stolen from automobiles apparently for the narcotics they contain. Since April 1, 1953 over forty physicians in different parts of the State have reported such thefts. Similar thefts have been reported from adjacent New York State. One physician's office also has been broken into and narcotics taken. This physician had expensive equipment in his office which was not touched.

So far four adolescents have been arrested in Hartford and charged with theft of narcotics from physicians' bags. These teen agers have admitted that many other physicians' bags have been opened and narcotics taken, but the bags have been left. Some physicians may have had their narcotic drugs stolen without realizing it. One youth, on questioning, admitted he had robbed at least fifty doctors of narcotics taken from their bags.

The following is a clue as to how these youths operate. These bags are usually stolen early in the morning from physicians' cars (identified by a doctor's insignia) parked at the various hospitals. Physicians are known to be at hospitals at this time of day. During the daytime and early evening youths also drive around to the offices of the various doctors looking for their automobiles. On finding a car with an insignia, they check to see whether the car doors are open or not.

If any physician has had his bag stolen and narcotics taken, he should follow the instructions given under Regulation 5, U. S. Treasury Department, Bureau of Narcotics, Article 194—Procedure in case of loss—

Where, through breakage of the container or other accident otherwise than in transit, narcotics are lost or destroyed, persons having the title thereby shall make affidavit as to the kinds and quantities of narcotics lost or destroyed and the circumstances involved, and immediately forward the affidavit to the narcotics district supervisor. A copy of such affidavit shall be retained and filed with other narcotic records.

Where narcotics are lost by theft, or otherwise lost or destroyed in transit, the consignee shall immediately upon ascertainment of the occurrence, file with the narcotic district supervisor, a sworn statement of the facts, including a list of the narcotics stolen, lost, or destroyed, and documentary evidence that the local authorities were notified. A copy of the sworn statement shall be retained in the file with the other narcotic records of the consignee.

Connecticut physicians should report narcotic thefts to the New England district supervisor who is Mr. T. J. Walker, narcotic supervisor, District 1, 1120 Post Office Building, Boston 9, Massachusetts. It is recommended by the State Department of Health that any physician having a bag stolen should notify the local or State police and also the division of narcotics of the State Department of Health. It is also suggested that all physicians make a careful check of narcotics and prescription blanks so they will be able to determine whether or not any of these items have been stolen. Forged prescriptions on stolen blanks are used as a means to obtain narcotics. All physicians, particularly those located in large office buildings where the cleaning personnel have a key, should make certain all narcotics, prescription blanks, and official order forms are kept under adequate safeguards. Locking of automobiles at all hospital, office and house calls should be routine. Only as small a supply of narcotics as is convenient should be kept in the medical bag, which should be carried by the doctor and not left in his car.

### Your Directory Information Card

The new, 19th Edition of the *American Medical Directory* is now in galley form, and it is expected

that the book will be ready for delivery about the middle of 1955. The previous edition was issued in 1950. Since that time, it has not been possible to publish a new edition because changes in the membership structure of the American Medical Association made it difficult to obtain an accurate list of members.

Within the next few weeks, a directory information card will have been mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. It is urged that physicians also fill out the right half of the card, which section requests information to be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, he should mail the card promptly to the Directory Department of the American Medical Association to insure an accurate listing of his name and address. There is no charge for publishing the data, nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations, and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and statistics on the distribution of physicians and hospitals in the United States.

### Aviation Medicine at Harvard

Graduate training related to the field of aviation medicine, a medical specialty recently certified by the American Board of Preventive Medicine, is being offered for the first time this year by the Harvard School of Public Health. The program directed by Ross A. McFarland, associate professor of industrial hygiene, meets the Board requirements of one year of graduate training in the areas of basic sciences related to aviation medicine and also will lead to a degree of master of public health.



## PROGRESS IN CLINICAL MEDICINE

### HIGHLIGHTS IN ORTHOPEDIC AND TRAUMATIC SURGERY IN PANAMA

CHARLES MURRAY GRATZ, M.D., *Greenwich*

IN ALL fields of human endeavor the personalities behind the highlights govern the length and the permanency of the shadows and images that finally emerge as history. The work of General Gorgas and his medical associates, particularly Daddy Deeks of McGill and Bill James from Virginia, not only made the building of the Panama Canal possible but established a foundation on which preventive medicine has been built and which assures its founders a secure place among immortals of our profession.

The epoch making advances of General Gorgas' Chief of Surgery, Alfred B. Herrick, and his colleagues have been as yet less dramatized than their medical associates. T. W. Earhart, Harry Eno, Edward Salisbury, Runyan, and F. Raymond are a part of the surgical team organized and trained by Herrick. As Edward Salisbury states, revolutionary work in traumatic surgery had been successfully accomplished and reported well before World War I started. The organizing ability of Herrick and his associates in the Republic of Panama, particularly Augustus Boyd, as well as their colleagues in neighboring Republics were responsible for introducing orthopedic surgery built on the firm foundation of well organized traumatic surgery.

In 1930 the bone carpentry of Albee<sup>2,3</sup> the fracture genius of Hawley,<sup>1</sup> and the beginning of biological engineering studies on the surgery of the spinal column<sup>4</sup> were introduced both to the Republic of Panama as well as to your society. From 1930 on Albee and the author operated in many of the American Republics and aided in the formation of traumatic and orthopedic departments in the universities and hospitals of these countries. The author's early work in the Republic of Panama was at the request and directly under the supervision of Albert B. Herrick. The establishing of the traumatic and orthopedic services at Santo Tomas Hospital with Augustus Boyd and his associates cooperating with the various surgical groups permitted completion of the entire surgical project before World War II involved this portion of the globe.

The Author. Associate Professor of Clinical Surgery (Traumatic and Orthopedic) New York Medical College, Flower Fifth Avenue Hospital. Associate Attending Orthopedic Surgeon, New York University and New York City Hospitals. Honorary Member National Medical Association of Panama

#### SUMMARY

The year 1954 celebrates the fiftieth anniversary of the beginning of the Panama Canal. This paper was presented in part at the Inter American Medical Convention celebrating this occasion.

George Hawley of Bridgeport, Fred Albee, and the author were members of the Pan American Flying Clinic who introduced certain new orthopedic and traumatic advances in eleven inter American countries in 1930.

Pioneer work in fascial surgery, living suture methods, particularly applied to the surgery of the lower spinal column, fractures and their sequelae, using biomechanical and biological engineering methods, are briefly reviewed for the last 24 years.

George Hawley's fracture methods and equipment, Fred Albee's and the author's work in establishing the inter-American division of Global Orthopedics are reviewed with particular reference to their surgical associates in these countries.

I would be remiss in not mentioning that from the day I first met Daddy Deeks in 1929 he, Connor, Macphail, Eno, Salisbury, Diaz, Cudlipp and their associates have made visiting these countries and their hospitals a true pleasure. The blending of pioneer traumatic limb saving techniques with modern orthopedic and rehabilitation surgery beginning in 1930 has resulted in sustained progress. The successful transplantation of biomechanical and living suture techniques from the United States of North America and Canada to this fair Republic may prove an integral part in laying a foundation of preventive surgery<sup>5</sup> paralleling the work in preventive medicine for which Gorgas, his associates and your country will be forever famous.

*Presented in part at the Inter-American Medical Convention, El Panama Hotel, Panama, Republic of Panama, C. A., on March 26, 1954. From Department of Orthopedic Surgery, New York University, Bellevue Medical Center, Walter A. L. Thompson, Director. Department of Orthopedic Surgery, New York Medical College, Flower and Fifth Avenue Hospital, New York City. Department of Surgery (Traumatic and Orthopedic) New York City Hospital, Welfare Island, Service of James H. Kidder*

A triple filter technique is necessary to weave new surgical achievements into the pattern of surgical progress. The work of Goethals the engineer, Gorgas, Deeks and Herrick the clinicians, was ably supplemented by a biologist who was also a pathologist of the first rank, namely, Herbert Clark.

In 1937 the author was presenting what was then a relatively new concept of fascial surgery which even then was believed to synchronize previously disconnected knowledge of the etiology and treatment of rheumatic diseases. Though the author had taught postgraduate surgeons this division of fascial surgery with fascial transplantation under the guiding eyes of Arthur Purdy Stout, Allen O. Whipple and Charles Gordon Heyd, there was then a definite weakness in the number of pathological biopsy specimens. The presentation at a special meeting of the Medical Association of the Isthmian Canal Zone was preceded by Herb Clark leaving a reprint published by him about two decades before in which his concept of rheumatic diseases was backed up by over one thousand consecutive pathological studies. It was indeed fortunate that we both agreed on certain of Arthur Steindler's findings in these conditions. With a never failing sense of humor associated with all meetings of this Society since the days of Gorgas, everything went across satisfactorily with the record of the forgotten work of Herbert Clark outshining the advances which we fortunately had not labeled new.

The overlapping fields of interest of the engineer, the surgeon, and the biologist, particularly in relation to the study of human locomotion and the biomechanics of surgery, date to antiquity. An historical review is adequately covered in Steindler's "Normal and Pathological Locomotion in Man."<sup>7</sup> It was not until the third and fourth decade of the twentieth century that biomechanical studies of the surgery of locomotion and biological engineering emerged as an entity. The publications of Arthur Steindler, the record of work of the New York biomechanical group and other bioscientists applying these principles are a matter of record both as to priority and methods of application. It was a matter of keen regret that the frailties of human nature delayed the general application of the surgery during World War II. We all, however, are indebted to G. B. Karelitz, Alexander Klemm,<sup>25a</sup> George Stetson, Hovgard,<sup>25</sup> and their associates in the American Society of Mechanical Engineers for making "Biomechanics, A New Approach to Airplane Safety," an established cornerstone in preventive surgery<sup>6</sup> with the proven record of saving the lives of combat aerial personnel an accomplished fact.

The unified safety wartime program is now the unified safety command. Rearward seating in fast moving human transports reported by Hovgard and the author and published in 1944 is now standard

equipment in many planes.<sup>6,25</sup> Fortunately the 1944 biomechanical program was planned for civilian as well as wartime safety. "The ground work . . . can be further advanced when combat hazards are no more."<sup>6</sup>

The 1954 look at vehicular crash research is spearheaded by Griswold of Kentucky, Campbell of Colorado, the Indiana State Police, and the proteges of Eugene Du Bois working through his alma mater Cornell. Organized medicine and the Committee of Trauma of the American College of Surgeons deserve congratulations on the civilian application of military techniques which have saved the lives of so many of our boys in uniform. In 1954 as in 1944 "The ultimate problem is the basic coordination of human defenses with structural protection."

The motor vehicle and its occupants are a single unit exactly paralleling the airplane. Modern car design must take advantage of the high physiological limits of elasticity of the human body and must include seating arrangements to permit the lower extremities and the spine to mechanically protect the chest, upper extremities and finally the head. Airplanes with poor ditching characteristics were dubbed "flying coffins" and are now as extinct as the dodo.

The transplantation of fascial structures as living sutures and pedicle grafts for stabilization has reached reasonable maturity.<sup>15</sup> Our whole concept, however, of fascial and capsular surgery is a neglected stepchild in human reconstruction. The classical work of Kanavel on the fascial spaces of the hand was the foundation on which Bunnell, Leo Mayer, Mason and later Littler and their associates have made respectable surgical progress. The functional mechanics of the soft structures which form part of the locomotor system were similarly studied by Codman in relation to the shoulder with gratifying results. Shoulder cuff tears and myofascial tears in the lumbosacral region are probably identical twins. It would be most unusual if anatomical and pathological lesions found and studied in these two locations did not similarly exist in the remaining parts of the complicated human chassis.

In the words of Arthur Steindler, "I should say that unless we have a pretty clear conception of the functional mechanics of the soft tissues which form part of the locomotor system we will not be able to go much further in the management of the legion of conditions which arise from the disturbances of these structures. It is necessary to look upon these substructures with the eyes of an engineer, as my dear old friend, Dr. Prentiss, has taught us, and to apply engineering principles to the mechanism of locomotion of the soft tissues among each other."<sup>10</sup>

Fortunately the new look or the new deal in answer to this challenge of Steindler's in 1935 has been partially answered and reported through official



surgical channels. Even more important the same biomechanical principles have withstood the test of time and have been taught as postgraduate surgical training, not only in the centers in which they were developed but also to the surgeons in Panama as well as other Central American countries.

The fascial planes and the ligamentous structures of the adult human body were found to have a uniform stress resistance of over 7,000 pounds per square inch.<sup>12</sup> This work, rather widely quoted, was found to extend to a representative cross section of the adult mammalian kingdom. It is of particular significance because of its close parallel to the electromicroscopic findings on connective tissue so brilliantly executed and reported by Schmitt and Gross of Massachusetts Institute of Technology. The gliding mechanism of the tendon in its sheath, the functional importance of motion in the pleural and peritoneal cavities have been studied and the findings applied for countless decades. The fact that a similar mechanism for synchronization of human locomotion in the fascial planes must exist was recognized in the middle thirties by my old friend and associate, G. B. Karelitz, director of Mechanical Engineering Research, Columbia University.<sup>13a</sup>

In the midthirties it took leaders like Herrick and Boyd of Panama to realize that visiting orthopedic surgeons, leaving behind them tangible proof of children walking after many years of being cripples, constituted living evidence of the good neighbor policy.

The work of the pioneers in fascial and capsular surgery has been reviewed. The biomechanics of fibrous tissues surgically applied to living suture work has been accompanied by a new armamentarium to simplify surgical techniques.<sup>13</sup> It is now very seldom necessary to make the second incision for securing of a living suture; half of any tendon can safely be removed without damaging the remaining portion.

The biochemical studies reported from many parts of the globe confirm the fact that the safety factor in the human body's locomotor apparatus is two. Fascial pedicle grafts are now frequently used as sutures and their improved nutrition has significantly increased their efficiency.<sup>15</sup> It is a source of no little pride to all members of the New York biomechanical group that the original biomechanical work on which these advances were made has been approved and is being published without charge in the official data of The National Research Council.<sup>16</sup> Even more important than such recognition is the fact that Steindler's writing and text books and the author's publications under the direct supervision of Arthur Steindler and Arthur Purdy Stout and their clinical applications stand without amendments but with continuous progress carefully biomechanically checked on secure foundations.

Personal clinical application of these biomechanical facts led to a preliminary report in 1949 on dynamic stability in fracture treatment.<sup>20,21</sup> This report was based on studies of over 1,000 fractures of the femur; the principles of dynamic balance leading up to dynamic equilibrium and in selected cases only reaching the final goal of dynamic stability.

It takes decades of applied surgical technique to realize that our synopsis really works in a semiautomatic manner. Before the days of instrument flying, pilots frequently flew by instinct or "by the seat of their pants." Biomechanist Lindbergh combines the homing instinct of the pigeon with the scientific approach leading to his advances in this field. Biomechanical progress is only made when conclusions that are readily reached by the semi-genius can be simplified, taught and duplicated by his associates.

A few ideas gleaned from a preliminary study of fractures of the femur at New York City Hospital since 1934, some previously reported with Arthur Fusco,<sup>21</sup> gives practical application to the above noted principles.

The late Smith Petersen's tri-fin pin in the treatment of fractures of the neck of the femur was and is regarded as one of the outstanding surgical advances since the turn of the century. In 1934 an epidemic of using multiple pins for fractures of the hip with insufficient care in selection of cases and technique in application led to rather unfortunate experiences in gathering up or removing such hardware. The reasons for these failures and the biomechanical study of the advantages of the Smith Petersen pin led to its introduction in 1935. The same basic principles, checked with Smith Petersen<sup>17</sup> himself, are still being used. Though many of this master's principles did not stand biomechanical scrutiny and hence were not used by our group, his work on intermedullary pinning of the hip was and is revolutionary.

With the exception of intermedullary fixation in the hand, the foot and the middle third of the femur, the use of hardware in the author's private practice is very sharply curtailed. It has, in spite of most conservative factors, been fraught with hazards which have at times almost equalled my old chief Fred Albee's belief that buried hardware was incompatible with modern orthopedic surgery. The author believes that modern bone grafting with living suture fixation combining the principles of Albee, Gallie and Lowman is the surgery of the future.

As early as 1935 and up to World War II George Karelitz, Philip Marvin and distinguished scientists from the Bell Laboratories, all highly trained engineers working with the author, perfected not one but many metallic devices for stabilization purposes in reconstructive surgery. Expanding head principles in pins for the hip and long bones, intermedullary pins that could be divided for ease of extraction

and automatic fascial strippers are a few of many devices that worked excellently on cadavers. The working models of many of these are being collected with pride because they were never used on humans and were never reported. Though there was a temptation to show them at the gadget division of the Academy's meetings, this was likewise resisted. Our biomechanical group not only believed but practiced the principle that any hardware placed in the human body should be up to rigid standards. Simplification and standardization of design should include ease of withdrawal of foreign material when necessary.

The effect of shearing stresses on osseous structures has been partially explored in a preliminary form only in the reconstructive surgery of the hip. The study of the role of shearing stresses in human fibrous tissues is a matter of record.<sup>12,21</sup>

The following quotations are taken from "Biomechanical Aspects of Bone Fusion"<sup>22</sup> in which the co-author is Lamont Grover, former chairman, Structural Steel Committee, Welding Research Council. "Engineering discussions of the merit of riveted or bolted metal fabrication as compared with welded fabrication have their counterpart in reconstructive surgery. An interchange of methods and techniques between the two professions could, if perfected, be expected to solve many similar problems in surgical reconstruction. The biomechanical division of biological engineering provides a foundation on which such an exchange of methods, principles, and eventually techniques could be successfully accomplished.

"Certain important considerations indicate a strong preference for the use of bone transplants for fusion as opposed to holding bones in position by metallic plates or splinters. There is likewise a preference for the technique of suturing fibrous tissues and bones with living tissues rather than using metallic ties or wires for passive opposition. Even if foreign materials could be controlled in chemical composition and fabrication to preclude corrosion and electrolytic action, there still remain innumerable bugs to be eradicated.

"We may draw upon fusion, welding and engineering principles for comparison with bone fusion as involved in the autogenous transplantation of bone. The surgical use of metallic splice plates or bone plates may be compared with riveted or bolted joints. By means of a fused welded butt joint in a steel member, the continuity of lines of stress is maintained across the joint while the parts are held in perfect apposition. In a riveted or bolted joint the lines of stress are deflected into the splice plates, and therefore an inefficient joint results, especially under dynamic loading such as shock loads or heavy loads repeated many times. Under these conditions the joint material may be loosened and permit the joint

to fail. Also, high local concentrations of stress occur, tending to produce failure. Thus the points of attachment for any kind of a splice plate are points of weakness where local stresses have been measured and found to be several times the normal stresses that occur at a properly fused structural joint."

From 1935 to the present each and every hip treated under the author's direction has been reduced and checked before any Smith Petersen pin was applied. Whether open or closed measures are used the fracture must be reduced and placed in dynamic balance as primary treatment.

Very definite ideas have been developed since the middle twenties on the extreme care necessary in treating patients in which infection has occurred around buried hardware. Complicated marine wrecks are excellent fishing grounds because they provide refuge for small and medium size fish protecting them from pursuit from their larger enemies. Complicated hardware that cannot be removed is an equally effective barrier to the many methods of controlling infection that the author or any of his associates have yet been able to find. The handling of patients with infected hardware is a problem in which antibiotics, blood transfusions, and other measures have a very limited field of usefulness and each case is a law unto itself. The work of Venables and the Austenol Company in the perfection of vitallium, the further work of Barr<sup>18</sup> and his committee, and the many years of hard work from the American College of Surgeons and the Bureau of Standards will doubtless conquer this problem completely. It is my sincere hope that these words of warning will shortly be unnecessary.

On the occasion of my first address in Panama<sup>4</sup> in 1930 the problem of differential diagnosis in conditions involving the lower spinal column and the technique in fusion of selected cases was presented. Even at that time controversies regarding the choice of patients for fusion and the type of fusion to be used were subjects of continuous debate. Goldthwaite's discovery of the intervertebral disc and its role and the fact that spinous processes had been wired for fusion at the turn of the century were relatively neglected. About the only fact that we are all in agreement on is that autogenous bone without metal and with adequate time for fusion, which even Albee and Hibbs agreed on, still stands.

The author with an adequately trained neurosurgeon and splendid cooperation from the orthopedic and neurological as well as the radiological departments of the Mayo Clinic investigated disc problems as well as doing pneumofasciograms at Post Graduate, now University Hospital, beginning in 1937.<sup>19</sup> Then as now we believe that disc pathology is merely one part of disturbed spinal function and is the secondary rather than the primary cause of the vast majority of low back syndromes. As in the



hand and in the shoulder myofascial tears, muscle and fascial herniations, ligamentous injuries causing adhesion formation and resulting impairment of nerve functions are believed to be of equal or greater importance than structures so carefully protected as the spinal column with the cord, lamina and discs.

The new concept of multiple small injuries and metabolic deficiencies being predisposing causes of the low back syndrome not only has been believed but practiced since 1930.<sup>23</sup> An orthopedic routine group of laboratory tests with the patient checked thoroughly by an internist has continued from the midthirties to the present.

Instability of the osseous structures of the lumbar spine and the sacrum as described by the Von Lackum brothers in the twenties is regarded as an advance ranking with those of Goldthwaite, Hibbs and Albee. Our studies of the biomechanics of fibrous tissue structures leads clinically to studies of dynamic stability of the fibrous tissues<sup>20</sup> supporting the osseous parts of the spinal column and its contents. Clinically these concepts blend without difficulty. Synchronization of motion, though complex, is best studied starting with the peripheral connective tissues, finally reaching those supporting the spinal column. The last and in the author's experience the least frequently damaged are the discs with their associated structures.

Pneumofasciograms<sup>24</sup> are used as an adjunct to localize fascial pathology. Fascial pedicle grafts<sup>15</sup> for the stabilization of spinal fusion and other clinical stepping stones as previously reported have done much to solve portions of the low back syndrome.

#### CONCLUSION

The fiftieth anniversary of the founding of the Panama Canal rightly honors the pioneers of the engineering and medical professions who transformed a dream into a reality. The living monument of their achievements has permanently altered inter-American cultural and scientific trends. No iron or bamboo curtain exists, even in nebular form in the western world. Scattered groups of medical men and engineers affectionately known as "tropical tramps" under inspired leadership became a mighty team. Their combined accomplishments accelerated by two global wars has conquered and prevented countless tropical diseases and formed a firm foundation for traumatic and later orthopedic surgery in the Americas.

Using the foundations established in osseous transplantations, the pioneer fascial surgery of the hand, and blending these with biomechanical studies of fibrous tissues, orthopedic advances were transplanted on the fertile fields of the Canal Zone and neighboring Republics. A mutual accord between the mechanical engineer, the pathologist, and the surgeon of human locomotion was the basis of our

biomechanical approach. It is gratifying to see that these techniques have withstood the test of time and have been supplemented in their application in the last two decades.

The future of the inter-American division of Harold Boyd's Global Orthopedics is now safely in the hands of many national societies.<sup>11</sup> The role of biomechanics, human kinetics and biological engineering is best visualized in the following words of Arthur Steindler,<sup>26</sup> "We see at long last with great satisfaction that kinetics of the human body has come into its own. It is to be expected that this will be a major issue in the future when the kinetics of the human body becomes fully accepted in clinical practice; when it is given equal rank with anatomy and pathology; and when it is finally realized that without this ancillary science no orthopedic training can be called adequate."

#### DISCUSSION

Dr. Edward I. Salisbury, Medical Director, United Fruit Company:

Dr. Gratz has called to our attention the early advances made in orthopedics in Panama. The Medical Association of the Isthmian Canal Zone entertained The Society of Clinical Surgery of the United States on the evening of March 29, 1913. At this meeting Dr. Alfred B. Herrick read a paper entitled "A Brief Outline of the Surgical Work at Ancon Hospital during the years 1910, 1911 and 1912." Several hundred x-ray plates were exhibited by Dr. Herrick and Dr. T. W. Earhart and many unusual and interesting surgical cases were presented. The surgeons present from the United States were astounded with the audacity of open operations for compound fractures and the magnificent results obtained. Among those present were Drs. George F. de Schweinitz, Robert G. Le Conte, G. W. Norris and John H. Gibbons, of Philadelphia; Drs. M. L. Harris and L. L. McArthur, of Chicago; Drs. C. H. Beck and E. Eliot, of New York City; and Dr. Roswell Park, of Buffalo, N. Y., practically all of whom favored the local society by taking part in the discussion. Dr. Gratz, in later years made various trips to this country (Panama) in order to train the young doctors of Santo Tomas Hospital in the newer orthopedic techniques and in the use of living fascial sutures.

Dr. Arthur Steindler, Iowa City, Iowa:

To me the most interesting angle of Dr. Gratz's paper which I had the pleasure of reading is how he describes the concomitant appearance of clinical venture and experimental approval in the field of bone and fascial reconstructive surgery. Maybe it would have been too much to expect of human impatience to give due precedence to the experimental work on the resistance of tissues which are used for mechanical purposes; but so far as fascial tissues are concerned experimental proof that they are suitable for stabilization purposes on the basis of their physical properties has not been long in coming. The credit for this must be given largely to Dr. Gratz's fundamental work on tension resistance of these structures.

The clinical use of bone for mobilization has been more precipitous following Albee and Hibbs; and, as you well know, the mechanical engineering is limping behind in deciding the adequacy or inadequacy of using bone graft in diverse situations on mechanical basis; and the flight of the metallic prosthesis into the strata of clinical application is still so unbridled that it may take decades before final

judgment is passed by the biologist and the mechanical engineer. Fortunately in the case of fascial surgery, the situation has become more mature. There is mutual accord in the triumvirate of the engineer, the biologist and the clinician. Dr. Gratz has shown that the mechanical requirements placed upon this tissue are met; and that it can be given secure anchorage has been proven by him, by Gallie and others; and he, as well as Gallie and Lowman, have succeeded in building up a sound basis for clinical application. If this is more than we can say at the present time for the clinical use of homogenous or autogenous bone and especially for the metallic prosthesis, it is in a large measure due to Dr. Gratz's fundamental investigation on the tension resistance of fascial structures.

#### ACKNOWLEDGMENTS

A probably inadequate effort has been made to mention the achievements and review the surgical history already written by the pioneers in our division of inter-American surgery. William J. Mayo of Rochester, Minnesota and his pioneer orthopedic surgeon, Melvin S. Henderson originally from the author's alma mater, University of Toronto, actively coordinated many of the rather far flung aspects of this project. Even in the twenties the former assisted and actually aided in publishing historical surgical data. Henderson throughout, even in the fifties, not only insisted on but gave organizational support toward establishing an as yet nebular foundation. Biomechanical facts successfully applied, taught, and transplanted beneath the epidermis of the patients from so many centers were not only believed by him but he insisted on making the methods, clinical application as well as the follow up data available to our entire profession.

Many surgeons in these countries were associated with Franklin Martin, the Mayos, and others in organizing the American College of Surgeons. I am indebted to Eleanor Grimm, now Historian of the College, for making personal as well as historic facts available to me.

The many courtesies extended from the thirties to the fifties by Karl Compton and the present leaders of Massachusetts Institute of Technology are gratefully acknowledged.

The minutes of the Proceedings of the early meetings of the Medical Association of the Isthmian Canal Zone, released through J. S. Cudlipp Medical Department of the United Fruit Company, are gratefully acknowledged.

I would be remiss if I did not mention the deletion of family duties borne by Sylvia S. and Alice S. Gratz as well as my only son when the urge of perfecting and applying new surgical techniques and rushing off to Central and South America to transplant them led to comical as well as semi tragic complications.

In addition to the hospitals, medical centers and universities who kindly officially sponsored this and previous publications and where the actual operating on clinic and private surgical patients was performed, I would be remiss if I failed to mention hospitals and institutions in Connecticut and Westchester where a large part of my private surgical practice is now carried out. From the middle twenties to the present the administrative, surgical and orthopedic staffs of New Rochelle and Norwalk Hospitals have made working there a true pleasure. The staffs of St. Joseph's Hospital in Stamford, United Hospital in Port Chester and the Greenwich Hospital Association as well as the Greenwich Medical Society have extended every courtesy and facilitated the surgical management and aided in the care of patients. The Panama Hospital and the Herrick Clinic now under the able leadership of my old friend D. F. Reeder has like the United Fruit Company with its far flung hospitals and facilities proved powers of strength in time of need.

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## THE PRESIDENT'S PAGE

### ACTIONS SPEAK LOUDER - - -

Recently a successful business executive from a neighboring State entered a Connecticut hospital in order to have a careful appraisal of his heart. He admitted that he was puzzled and anxious. A year earlier a diagnosis of coronary thrombosis had been made on the basis of a single electrocardiogram which was suggestive but not conclusive. There had been no symptoms referable to the heart at that time or later. Nevertheless, his physician promptly requested him to curtail his business and social activities, to abstain from tobacco and alcohol, to avoid golf and similar physical exertion, to install an elevator in his home, to rest for one hour four times a day, to retire at 9 P. M., and to take a number of medicines. However, he was frequently assured that he was making satisfactory progress, that his heart was in excellent condition, and that there was no cause for worry!

This man had a number of friends who had sustained unquestionable "heart attacks," and they had resumed all or most of their normal activities after a few weeks of convalescence. When he mentioned this to his physician and asked why he was so greatly restricted when he felt perfectly well, he received vague or highly technical explanations that were far from convincing. After many months of increasing discontent and decreasing confidence in his doctor, he decided to seek other opinions.

For the moment criticism is not directed toward the details of treatment, but rather to the obvious contradiction between the physician's words and actions. Is it not absurd and futile to say one thing in words and simultaneously to say the exact opposite in actions that speak far more eloquently and convincingly?

This case is admittedly a rather extreme one, but the situation in less extreme form is encountered often. It is probable that similar examples occur more frequently in cases of coronary thrombosis than in almost any other illness. Of all the conditions known to me this is the one that is most frequently "over-treated" from the moment of onset. Many otherwise excellent doctors, upon encountering a patient who has even mild cardiac infarction, seem to forget that the chances of complete recovery are very great. Their attitude implies clearly that death may occur at any moment. Their patients are forbidden to make the slightest movement without help, they are kept in oxygen tents long after the need for this has passed, all salt is removed from the diet, they are fed by the nurse for weeks, and they receive a wide variety of medicines. In these circumstances, how can any person escape the deep and lasting conviction that he must be seriously, even critically, ill?

Fortunately, most patients recover their physical health despite these discouraging conditions, but the emotional invalidism that develops in many may have its origin in the disturbing attitude so clearly displayed by excessive restrictions. If a man has to spend six or eight weeks at complete rest in a hospital, an equal period resting at home, and has not been permitted to return to his quiet executive duties at the end of six months, he becomes increasingly certain that the injury to his heart must have been very serious. The average non-medical person believes that the heart is an extremely delicate organ, and that any change in it may result in invalidism or death. Consequently, over-solicitude on the part of the physician may easily cause anxiety, constant apprehension, and ultimate inability to lead a normal life, even though the heart has not been impaired. Of what avail are mere words of comfort against the deafening shouts of actions that pointed unmistakably to prolonged and critical illness?

These comments are intended as a gentle reminder of a common and seductive error that will be made seldom if its potential seriousness is recognized. Let each of us strive earnestly to avoid those actions and attitudes which proclaim our concern so loudly that all our later words of advice and reassurance must fall on deaf ears.

H. M. Marvin, M.D.

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## THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH  
*Director of Public Relations*

JOSEPHINE P. LINDQUIST  
*Administrative Assistant*

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### COUNCIL MEETING

The monthly meeting of the Council was held at the offices of the Society on November 10, 1954. The meeting was called to order by the Chairman at 4:00 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Marvin, Stringfield, Couch, Gilman, Barker, Weld, Murdock, Gildersleeve, Gibson, Feeney, Fincke, Gallivan, Tracy, Russell, Labensky, Gens, Clarke, Buckley, Dwyer. Absent: Drs. Ursone, Flaherty, Ottenheimer, Walker, Archambault. By invitation Dr. William G. H. Dobbs, Chairman of the Committee on Public Relations and Mrs. Joseph P. Lindquist, Administrative Assistant.

The by-law amendments relating to the status of Alternate Councilors, the Speaker and Vice-Speaker of the House of Delegates that had been proposed by the Council subcommittee were reviewed. Certain corrections were made and the amendments were then approved for presentation at the House of Delegates meeting on December 9.

The budget for 1955 was presented by the Treasurer Dr. Couch. It was discussed in some detail and finally approved as presented with the recommendation that dues for 1955 be fixed at \$28. The recommendation will be submitted to the House of Delegates on December 9. It was voted to express appreciation to Mrs. Lindquist for the preparation of the budget.

The proposal that the Society make a contribution to the American Medical Education Foundation which had been referred to the Budget Committee by the Council on October 13 was brought up by Dr. Couch. He stated that the matter had been discussed by the Budget Committee and that amounts from \$1,000 to \$2,750 had been proposed and that the Budget Committee was of the opinion that an amount was desirable but that it should come from the unallotted surplus funds of the Society and not be included in the budget as an operating expense. It was voted that \$1,000 from the surplus funds of the Society be contributed to the American Medical Education Foundation in 1955.

A request was presented from the Committee on Public Relations for an additional allotment of \$1,400 for expenditures during the year 1954. Dr. William G. H. Dobbs, chairman of the committee, explained the reasons for the unbudgeted expenses. It was voted to approve the additional sum of \$1,400 for the Public Relations Committee. (AMB 11/10/54 "A".)

Dr. Stringfield reported for the subcommittee that had been appointed to review the subject of the inclusion of osteopaths licensed to practice medicine and/or surgery in the Connecticut Medical Service contract. The subcommittee which consisted of Drs. Stringfield, Gens, Gildersleeve reported that it is unanimously of the opinion that when medical or surgical services are rendered to CMS members by osteopaths licensed to practice medicine and/or surgery under Section 4375 of the General Statutes that their services be paid for in the same manner as when services are rendered by doctors of medicine and that osteopaths licensed to practice medicine and/or surgery be urged to become participating physicians in Connecticut Medical Service. After considerable discussion the recommendation of the committee was unanimously adopted and the Board of Directors of Connecticut Medical Service is to be informed accordingly.

A report from the Special Committee to Study Third Party Payments for Medical and Ancillary



Nonsurgical Services (White Committee) was presented and discussed at length. It was voted that the committee be informed that the Council wishes to have the full committee confer with the Professional Policy Committee of Connecticut Medical Service and after that conference submit a further report to the Council. (AMB 11/10/54 "B".)

A supplemental report from the Committee to Study Third Party Payments for Medical and Ancillary Nonsurgical Services was also presented. This supplemental report related to the proposal that the membership of the Professional Policy Committee of Connecticut Medical Service be increased from nine members to twelve members. The Special Committee approved of this proposal that had previously been approved by the Council and the secretary was directed to again transmit this recommendation to the Board of Directors of Connecticut Medical Service with the view that the By-laws of Connecticut Medical Service be amended so as to increase the membership on the Professional Policy Committee. (AMB 11/10/54 "C".)

A letter was presented from Ralph T. Ogden, chairman of the Committee on Hospitals, asking that the Society seek an opinion from the Attorney General of the State of Connecticut in regard to the legality of hospitals employing physicians on full time salary and collecting fees for their services. The secretary explained that the State Medical Society has no privilege to ask legal opinions from the Attorney General of the State of Connecticut but that the Connecticut Medical Examining Board, a State agency, had asked the Attorney General for opinion on this matter and the deliberations are now pending.

Dr. Marvin reported concerning an invitation from Dr. Frank P. Foster, chairman of the Massachusetts Committee on Arrangements for the Interim Session of the American Medical Association that will be held in Boston, December 1955. Dr. Foster had asked Dr. Marvin to invite the Connecticut State Medical Society to appoint a member to serve on the Committee on Arrangements for the Boston session of the American Medical Association and have the Society's executive secretary serve also as a member of that Committee. It was voted to accept this invitation and Dr. Marvin was named to serve as the Society's representative on the Committee. The possibility that the Society might participate financially in the meeting was discussed and it was concluded that Dr. Marvin should report to the

Council at a later meeting and make a recommendation concerning an appropriation of funds for this purpose if it is desirable.

An invitation was presented from the Connecticut Tuberculosis Association for the Society to be represented at an Interagency Conference on tuberculosis case finding on December 1. Dr. Walter I. Russell was appointed.

The resignation of Clair B. Crampton as a member of the Committee on Public Health was accepted and Clarence W. Harwood, Middletown, was appointed in his place.

Lewis P. James, Hartford, was appointed an additional member of the Committee to Study Maternal Mortality and Morbidity in accordance with a suggestion made by the chairman of the committee, Carl E. Johnson.

The secretary was instructed to ask the presidents and secretaries of the county associations if they wished to have the Conference of County Association Officers, which was omitted in 1954, in 1955. The opinion of the county association officers is to be reported to the Council at a subsequent meeting to determine if the Conference is to be held.

A report was presented on the content of the course on Economics and Public Relations in Medical Practice that is to be given in the Yale School of Medicine. (AMB 11/10/54 "D".)

Fourteen student members were elected.

It was agreed that the December meeting be omitted unless urgent matters arise from the House of Delegates meeting on December 9. The meeting in January will be called by the chairman.

Dr. Dwyer, alternate councilor from New Haven County, spoke briefly concerning an article in the current issue of "Guild Craft" in regard to optometrists being the only persons qualified to do eye refraction.

The meeting adjourned at 6:00 P. M., following which the gentlemen of the Council dined with the members of the Professional Policy Committee of Connecticut Medical Service at the New Haven Lawn Club.

### Student Members

Ralph A. Bohm, Hartford  
Howard University—Class of 1958  
Pre-Med: University of Connecticut  
Parent: Martin Bohm

David A. Carlson, West Hartford  
Yale University School of Medicine—Class of 1958  
Pre-Med: Bowdoin College  
Parent: David E. Carlson

John A. Creatura, Bridgeport  
Yale University School of Medicine—Class of 1958  
Pre-Med: Yale University  
Parent: Grazio A. Creatura

Joseph M. Gromults, Jr., Seymour  
NYU College of Medicine—Class of 1958  
Pre-Med: Yale University  
Parent: Joseph M. Gromults, Sr.

Sylvia F. Havelka, Essex  
Johns Hopkins—Class of 1958  
Pre-Med: Tufts College  
Parent: Frank Havelka

Francis M. Jackson, New Haven  
University of Vermont College of Medicine—  
Class of 1958  
Pre-Med: University of Vermont  
Parent: Andrew A. Jackson

Lewis P. James, Jr., West Hartford  
Harvard Medical School—Class of 1958  
Pre-Med: Yale University  
Parent: Lewis P. James, M.D.

Jack M. Matloff, West Haven  
Tufts Medical College—Class of 1958  
Pre-Med: Yale University  
Parent: Hyman Matloff

Harold Ross, Waterbury  
Northwestern University Medical School—  
Class of 1958  
Pre-Med: University of Connecticut  
Parent: Joseph Ross

Harvey P. Rubin, Waterbury  
University of Vermont College of Medicine—  
Class of 1958  
Pre-Med: University of Connecticut  
Parent: Meyer Rubin

Edward M. Segall, Waterbury  
Howard University School of Medicine—Class  
of 1958  
Pre-Med: Brown University  
Parent: Samuel B. Segall

Edmund H. Sonnenblick, West Hartford  
Harvard Medical School—Class of 1958  
Pre-Med: Wesleyan University  
Parent: Ira J. Sonnenblick

James H. Tyer, Bridgeport  
University of Maryland Medical School—Class  
of 1958  
Pre-Med: University of Vermont  
Parent: James H. Tyer

George W. Valentine, West Haven  
New York Medical College—Class of 1955  
Pre-Med: Yale University  
Parent: Mrs. L. K. V. Taylor

## Meetings Held During November

- November 3—Committee to Study Maternal Mor-  
tality and Morbidity  
Advisory Committee to State Wel-  
fare Department
- November 4—Committee on Public Health  
Special Committee to Study Third  
Party Payments for Medical and An-  
cillary Nonsurgical Services
- November 5—Advisory Committee to State Nurses  
Examining Board
- November 8—Office Staff Conference
- November 9—Connecticut Medical Examining  
Board
- November 10—Connecticut Medical Examining  
Board  
Council  
Professional Policy Committee of  
CMS
- November 12—Advisory Committee to State Tuber-  
culosis Commission
- November 15—Conference on National Legislation  
Advisory Committee to Bureau of  
Rehabilitation
- November 17—Medical Advisory Committee Con-  
necticut Blood Center  
Board of Medical Visitors—Institute  
of Living
- November 18—Connecticut Committee on Ameri-  
can Medical Education Foundation
- November 23—Connecticut Medical Examining  
Board  
Advisory Committee Connecticut  
Blood Center



## New Members

### TOLLAND COUNTY

Oliver J. Purnell, Rockville

### WINDHAM COUNTY

Robert P. Bowen, Coventry

### HARTFORD COUNTY

John W. Bengtson, Rocky Hill  
 John J. Blasko, Hartford  
 Richard B. Brown, Hartford  
 Lawrence S. Carlton, Collinsville  
 Roger G. Conant, Hartford  
 Joseph C. Cullina, West Hartford  
 Jean G. de Chabert-Ostland, Hartford  
 Cleveland R. Denton, Hartford  
 A. Arthur Fierberg, Hartford  
 Nicholas A. Giosa, Hartford  
 Harry R. Gossling, Hartford  
 Don A. Guinan, Manchester  
 Thomas S. Hamilton, Hartford  
 Thomas R. Huleatt, Jr., Hartford  
 Harry B. Kaitz, Hartford  
 Charles R. Kiefer, Jr., Hartford  
 Paul J. Kingston, Hartford  
 Edwin M. McCloskey, Hartford  
 Wilfrid L. McDonald, Hartford  
 Robert J. Molloy, Hartford  
 Mogens A. Plessen, Hartford  
 Joseph E. Rosenfeld, Hartford  
 Edward H. Scheer, New Britain  
 Carey Q. Stanton, Hartford  
 Howard J. Welch, Hartford  
 Seymour Werthamer, Hartford  
 Howard J. Wetstone, Hartford  
 Robert L. Whitney, Hartford  
 Edmund F. Ziegler, New Britain

### NEW HAVEN COUNTY

Richard L. Barach, West Haven  
 Merrill A. Baratz, New Haven  
 Gerard A. Barnaby, Waterbury  
 Annette J. Benoit, West Haven  
 George A. Bonner, New Haven  
 James P. Burke, New Haven  
 Robert E. Cooke, New Haven  
 Douglas H. Cownie, Wallingford  
 Felice M. Emery, New Haven  
 Stuart C. Finch, New Haven  
 Paul S. Goldstein, New Haven  
 Martin E. Gordon, West Haven

Richard H. Granger, New Haven  
 Robert N. Hamburger, Milford  
 Henry H. Hart, Southbury  
 John M. Hoffer, Ansonia  
 Ernest M. Izumi, North Haven  
 John F. Kramer, New Haven  
 Sidney B. Luria, Waterbury  
 Gilbert Manheim, New Haven  
 John C. McLaughlin, New Haven  
 Robert T. McSherry, New Haven  
 Alan C. Mermann, Guilford  
 Jacob H. Milstone, New Haven  
 Girard F. Nardone, Derby  
 Robert Navarre, New Haven  
 Robert F. Newton, Hamden  
 Olindo O. Santopietro, Waterbury  
 Edward H. Scherr, New Haven  
 Emanuel E. Schwartz, New Haven  
 Edward Shanbrom, West Haven  
 Harrison Shapiro, New Haven  
 Donald P. Shedd, New Haven  
 Eugene Sillman, Meriden  
 Kenneth Sterling, New Haven  
 Said H. Tarabishy, Waterbury  
 William M. Terry, New Haven  
 Stephen Troubalos, Milford  
 Gertrude J. Vermande-Van Eck  
 Herbert E. Weisberg, Waterbury  
 Joseph Zimmerman, Meriden

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## Scientific Exhibit American Medical Association Meeting Atlantic City, June 6-10, 1955

Applications for space in the Scientific Exhibit for the Atlantic City Meeting must be submitted before January 10, 1955. Applications will be acted on by the Council on Scientific Assembly as soon as possible after that date, and notification sent to exhibitors.

An endeavor is made to assign to each exhibitor space according to his requirements, as far as the limits of the hall will allow. Applicants should request the minimum space actually needed. The exhibits will be placed, so far as possible, in groups corresponding to the sections of the Scientific Assembly. Detailed information can be obtained from the secretary's office, New Haven.

## Mrs. Vestal Elected to Represent Woodbridge in General Assembly



MRS. PAUL W. VESTAL

The voters of Woodbridge went to the polls on election day and named Mrs. Ina Vestal, wife of Dr. Paul W. Vestal, their first woman representative to the General Assembly.

Mrs. Vestal won the election as a Republican candidate by a plurality of 725 votes over the 490 votes cast for Gilbert Martin, Democrat.

The new Woodbridge representative brings to office extensive experience in public affairs and organization activities.

She has held membership on the Republican Town Committee for her community since 1944 and during the past three years has served as its vice chairman.

A delegate to three Republican state conventions, Mrs. Vestal was named an alternate delegate to the Republican National Convention in 1952.

She has served as secretary of the Woman's Auxiliary to the State Medical Society and as editor of its official publication, previously titled *The Bulletin* and now known as *The Connecticut Quarterly*.

Active in the affairs of the League of Women

Voters, she has served as the League's public relations chairman for Connecticut and for the New Haven area. For several years Mrs. Vestal authored *Washington Digest*, an analysis of national legislative measures for the League's official publication, *The Connecticut Voter*.

Early this year she was appointed a Connecticut delegate to the President's Conference on Highway Safety, held in Washington, D. C.

Mrs. Vestal's interest in hospital affairs brought her election as a member of the Board of Directors of the Woman's Auxiliary to the Grace-New Haven Community Hospital and as vice president in charge of public relations. During the past three years she has been co-chairman of the Political Education Committee of the New Haven County Woman's Republican Club.

Her political views coincide with Republican concepts, but she has expressed a frankly individual approach to certain community problems. In education, for instance, she believes so much emphasis has centered on new buildings to relieve overcrowded classrooms that we have slighted the teacher problem. She believes the qualifications of teachers should receive equal emphasis with the admittedly necessary expansion of school facilities, and that incentives should be provided to encourage employment of teachers of superior ability and training.

Adequate care for the State's mentally ill is also of prime concern to Mrs. Vestal. Her interest in this problem is backed by prior service as a member of the Board of Directors of the Connecticut Association for Mental Health. Also of top interest are the problems of providing proper care for the chronically ill and aged and for needy children.

She favors cutting of costs by reducing wasteful government operations and feels that the people should be constantly informed concerning the costs of new services or facilities which appear to be in public demand.

Employment stability and expanding opportunities for a growing population can best be assured, she feels, by maintaining conditions encouraging to business, industry and farming.

Born in Ausable Forks, New York (Ina Featherston), Mrs. Vestal attended Gardner School in New York City, was married in 1926, and has two sons. Edward, the eldest, now resides in Aspen, Colorado, following service in Korea and Japan with the United States Air Force. Paul, Jr., is attending the Army Language School at the Presidio of Monterey, California, and is studying Russian.



## FUNDS FOR THE MEDICAL SCHOOLS

A list of the July, 1954, grants to the medical schools by the American Medical Education Foundation and the National Fund for Medical Education

SCHOOLS	UNDERGRADUATE		NO. OF		DESIGNATED GRANTS	TOTAL GRANTS
	CLASS A GRANTS	STUDENT ENROLLMENT	CLASS B GRANTS	DESIGNATED GIFT DONORS		
1. Medical College of Alabama.....	\$ 15,000.00	311	\$ 7,775.00	15	\$ 965.00	\$23,740.00
2. University of Arkansas.....	15,000.00	317	7,925.00	31	1,239.00	24,164.00
3. College of Medical Evangelists.....	15,000.00	372	9,300.00	59	9,343.90	33,643.90
4. Stanford University .....	15,000.00	240	6,000.00	57	5,860.92	26,860.92
5. University of California.....	15,000.00	315	7,875.00	15	2,083.34	24,958.34
6. University of Southern California.....	15,000.00	277	6,925.00	22	2,673.58	24,598.58
7. University of Colorado.....	15,000.00	308	7,700.00	272	7,205.42	29,905.42
8. Yale University .....	15,000.00	322	8,050.00	70	2,210.00	25,260.00
9. George Washington University.....	15,000.00	376	9,400.00	37	1,271.00	25,671.00
10. Georgetown University .....	15,000.00	444	11,100.00	70	3,190.00	29,290.00
11. Howard University .....	15,000.00	304	7,600.00	18	370.85	22,970.85
12. Medical College of Georgia.....	15,000.00	330	8,250.00	18	1,104.00	24,354.00
13. Emory University .....	15,000.00	285	7,125.00	25	1,557.50	23,682.50
14. Chicago Medical School.....	15,000.00	284	7,100.00	736	14,785.00	36,885.00
15. Northwestern University .....	15,000.00	532	13,300.00	758	19,822.50	48,122.50
16. Stritch School of Medicine.....	15,000.00	337	8,425.00	94	3,792.50	27,217.50
17. University of Chicago.....	15,000.00	282	7,050.00	97	3,553.50	25,603.50
18. University of Illinois.....	15,000.00	665	16,625.00	98	3,141.00	34,766.00
19. Indiana University .....	15,000.00	583	14,575.00	632	19,792.34	49,367.34
20. State University of Iowa.....	15,000.00	464	11,600.00	132	5,743.00	32,343.00
21. University of Kansas.....	15,000.00	459	11,475.00	65	3,020.00	29,495.00
22. University of Louisville.....	15,000.00	388	9,700.00	61	2,775.33	27,475.33
23. Louisiana State University.....	15,000.00	447	11,175.00	11	482.50	26,657.50
24. Tulane University .....	15,000.00	517	12,925.00	74	3,793.83	31,718.83
25. John Hopkins University.....	15,000.00	289	7,225.00	99	3,701.10	25,926.10
26. University of Maryland.....	15,000.00	389	9,725.00	92	3,373.50	28,098.50
27. Boston University .....	15,000.00	288	7,200.00	39	2,250.00	24,450.00
28. Harvard Medical School.....	15,000.00	532	13,300.00	116	4,821.00	33,121.00
29. Tufts College Medical School.....	15,000.00	451	11,275.00	69	2,683.83	28,958.83
30. University of Michigan.....	15,000.00	759	18,975.00	127	7,555.50	41,530.50
31. Wayne University .....	15,000.00	280	7,000.00	32	1,603.50	23,603.50
32. University of Minnesota.....	15,000.00	490	12,250.00	147	8,512.75	35,762.75
33. University of Mississippi.....	7,500.00	117	2,925.00	29	595.00	11,020.00
34. St. Louis University.....	15,000.00	484	12,100.00	82	4,693.79	31,793.79
35. University of Missouri.....	7,500.00	88	2,200.00	10	213.81	9,913.81
36. Washington University .....	15,000.00	367	9,175.00	86	3,246.30	27,421.30
37. Creighton University .....	15,000.00	309	7,725.00	197	28,896.50	51,621.50
38. University of Nebraska.....	15,000.00	340	8,500.00	136	8,874.00	32,374.00
39. Dartmouth Medical College.....	7,500.00	48	1,200.00	36	1,052.50	9,752.50
40. Albany Medical College.....	15,000.00	220	5,500.00	28	1,005.00	21,505.00
41. Columbia University .....	15,000.00	476	11,900.00	63	1,815.00	28,715.00
42. Cornell University .....	15,000.00	338	8,450.00	107	3,401.00	26,851.00
43. New York Medical College.....	15,000.00	482	12,050.00	33	660.00	27,710.00
44. New York University.....	15,000.00	526	13,150.00	86	2,902.50	31,052.50
45. State University of New York, Brooklyn	15,000.00	574	14,350.00	21	430.00	29,780.00
46. State University of New York, Syracuse	15,000.00	285	7,125.00	18	638.00	22,763.00
47. University of Buffalo.....	15,000.00	288	7,200.00	178	3,110.00	25,310.00
48. University of Rochester.....	15,000.00	277	6,925.00	36	1,268.00	23,193.00
49. Duke University .....	15,000.00	316	7,900.00	21	720.00	23,620.00
50. Bowman-Gray School of Medicine.....	15,000.00	207	5,175.00	11	1,125.00	21,300.00
51. University of North Carolina.....	15,000.00	242	6,050.00	12	545.00	21,595.00
52. University of North Dakota.....	7,500.00	78	1,950.00	25	917.50	10,367.50

FUNDS FOR THE MEDICAL SCHOOLS—*Continued*

SCHOOLS	UNDERGRADUATE		NO. OF		DESIGNATED GRANTS	TOTAL GRANTS
	CLASS A GRANTS	STUDENT ENROLLMENT	CLASS B GRANTS	DESIGNATED GIFT DONORS		
53. Ohio State University.....	15,000.00	573	14,325.00	131	5,073.00	34,398.00
54. University of Cincinnati.....	15,000.00	345	8,625.00	74	3,595.00	27,220.00
55. Western Reserve University.....	15,000.00	331	8,275.00	92	4,755.00	28,030.00
56. University of Oklahoma.....	15,000.00	391	9,775.00	29	1,532.00	26,307.00
57. University of Oregon.....	15,000.00	288	7,200.00	79	3,497.50	25,697.50
58. Hahnemann, Philadelphia.....	15,000.00	396	9,900.00	163	5,485.00	30,385.00
59. Jefferson Medical College.....	15,000.00	666	16,650.00	209	5,970.00	37,620.00
60. Temple University.....	15,000.00	517	12,925.00	125	4,447.50	32,372.50
61. University of Pennsylvania.....	15,000.00	510	12,750.00	329	9,976.00	37,726.00
62. University of Pittsburgh.....	15,000.00	376	9,400.00	158	5,832.70	30,232.70
63. Woman's Medical, Pennsylvania.....	15,000.00	181	4,525.00	42	1,745.00	21,270.00
64. Medical College of South Carolina.....	15,000.00	301	7,525.00	22	684.00	23,209.00
65. University of South Dakota.....	7,500.00	65	1,625.00	89	4,268.00	13,393.00
66. University of Tennessee.....	15,000.00	750	18,750.00	53	2,193.09	35,943.09
67. Meharry Medical College.....	15,000.00	257	6,425.00	7	148.34	21,573.34
68. Vanderbilt University.....	15,000.00	206	5,150.00	34	1,532.00	21,682.00
69. Baylor University.....	15,000.00	358	8,950.00	58	3,415.00	27,365.00
70. University of Texas.....	15,000.00	597	14,925.00	80	2,313.90	32,238.90
71. Southwestern Medical School.....	15,000.00	394	9,850.00	11	745.00	25,595.00
72. University of Utah.....	15,000.00	208	5,200.00	22	1,620.00	21,820.00
73. University of Vermont.....	15,000.00	195	4,875.00	155	6,079.50	25,954.50
74. University of Virginia.....	15,000.00	289	7,225.00	88	4,326.19	26,551.19
75. Medical College of Virginia.....	15,000.00	365	9,125.00	62	2,015.00	26,140.00
76. University of Washington.....	15,000.00	287	7,175.00	27	1,231.90	23,406.90
77. Marquette University.....	15,000.00	398	9,950.00	61	3,595.00	28,545.00
78. University of Wisconsin.....	15,000.00	321	8,025.00	33	1,630.00	24,655.00
79. West Virginia University.....	7,500.00	61	1,525.00	26	1,113.00	10,138.00
80. University of Puerto Rico.....	15,000.00	183	4,575.00	0	0	19,575.00
Totals.....	\$1,155,000.00	28,508	\$712,700.00	7,662	\$309,204.71	\$2,176,904.71

A.C.S. Regional Committee on Trauma  
Meets

A meeting of the Connecticut Regional Committee on Trauma of the American College of Surgeons was held at the Greenwich Hospital on October 21.

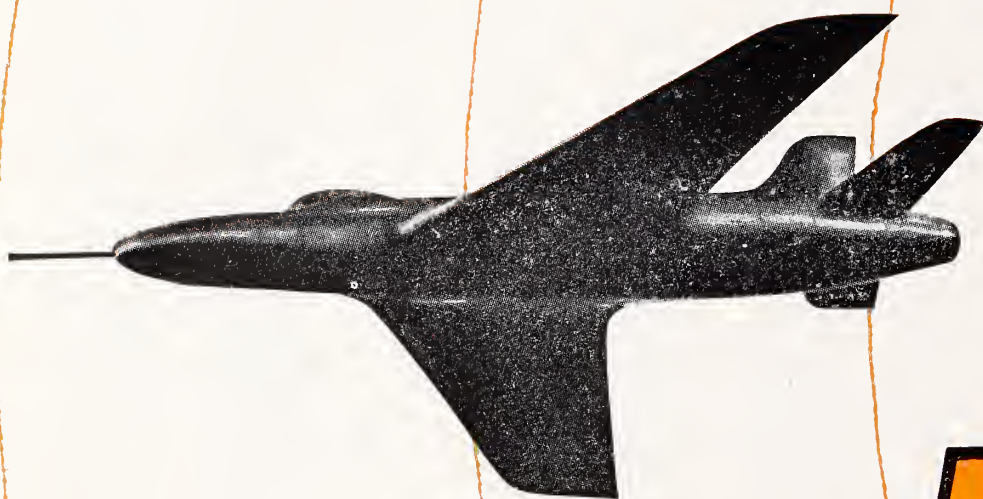
Howard P. Serrell arranged this meeting, the high points of which were the presentations of cases by T. Campbell Thompson and M. Beckett Howorth, but perhaps the most important were improvements in the technic of insertion of the Smith Petersen nail which was presented by Henry B. Crawford, assistant professor of orthopedic surgery at the Rochester General Hospital. These improvements were of a sort that some people might call minor, but in fact are refinements that make all the difference between an unhappy nailing of the hip and a perfect one. It

is suggested that if anyone is interested in the details of these developments he should talk to a member of the Connecticut Regional Committee on Trauma who attended the meeting, or join the Regional Committee on Trauma.

Edwin F. Cave, chief of fracture service and visiting orthopedic surgeon at the Massachusetts General Hospital, discussed fractures of the acetabulum, and pointed the way through simple conservative measures in which a good result could be obtained in a majority of cases. This contribution was very important when viewed in the light of problem cases presented from and by the staff of the Greenwich Hospital.

The entire meeting was extremely important as representing progress and treatment of trauma to the hip.





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## THE HISTORIAN'S NOTE BOOK

### THE DOCTORS OF THE HARTFORD HOSPITAL 1854-1954

STANLEY B. WELD, M.D., *Hartford*

The Author. *Gynecologist and Obstetrician,  
Hartford Hospital, Hartford, Connecticut*

ANY history is a chronicle of events; such events depend on two factors, people and places. The history of Hartford Hospital is no exception. The doctors of Hartford have always played a prominent part in its development, as rightly they should, and although, as Mrs. Hewes has so fittingly written in her "Hartford Hospital; A Century of Service," the Hartford Hospital was a community affair, "of the people, by the people, for the people," we shall concern ourselves with those stalwart physicians who established and maintained a reputation for their hospital enjoyed by few other contemporary institutions of a similar character.

Attention has been called frequently in recent weeks to the initial steps in the development of our hospital: the crowded public meeting on May 2, 1854 following the disaster at the Fales and Gray car factory; the act of incorporation passed by the General Assembly that same year and signed by the Governor; the taking over of the Christ Church "Home for the Sick" and the appointing of a staff of physicians for this, the first Hartford Hospital; the laying of the cornerstone of the new building at 4:00 P. M., May 27, 1857, the dedication in 1859, and the opening to patients on August 1, 1860. In his presidential address before the Connecticut Medical Society in 1857 Dr. B. H. Catlin of West Meriden has this to say: "Passing through the south part of the city (Hartford) a few years since, I saw before me what appeared in the distance to be a private mansion, but having a sign over its principal entrance, which as I approached nearer I found to be 'Home for the Sick.'

"Upon one who had practised many years in a thriving village . . . such a sign made a deep impression—Home for the Sick! How many young

men and young women too have suffered and perhaps died for the want of a home when sick? . . .

"I understand the citizens of Hartford have raised their 'Home for the Sick' to the dignity of a Hospital. I would advise them to retain the original name, for many persons have strong prejudice against a hospital, unreasonable, yet real, that would not exist towards a 'Home for the Sick.' . . . If we are to have homes for the sick established, as they should be, in all our principal towns and villages, you, gentlemen, and your associates, must commence and carry on the work. The funds must come from benevolent individuals, from state and town authorities, but the real work must be performed by our profession." One hundred years have not altered this forecast one iota.

A quick glance at the city itself in 1854 produces a picture difficult for some of the younger members of our profession to visualize. Hartford's population was about one-tenth the present census. Dirt streets existed, deep in mud after a heavy rainfall. Two wheeled and four wheeled vehicles passed up and down the streets but for rapid transportation over the countryside the horse's back was still the best method. River traffic was popular; rail service had connected Hartford with New Haven since 1844 and with New York City since 1848. The health conditions are well itemized in the sanitary report to the State Medical Society in 1855 by Dr. Gurdon W. Russell, one of the six to form the first medical and surgical staff at the Hartford Hospital.

"The general Hygienic character and condition of the town is one of healthiness. There are no large marshes, or standing pools or bodies of water near by, to cause pernicious exhalations, and the ground is generally considerably elevated above the river. Main Street is perhaps fifty feet above low water mark. . . . The soil is exceedingly varied . . . Generally speaking, in the immediate vicinity of the city it might be termed a clayey loam.

At the south the clay predominates; to the north, there is more sand; to the west and north-west a mixture of clay and gravel."

Speaking of Mill River (since variously labelled Park and Hog River) Dr. Russell says: "In the summer months this stream is so poorly supplied that the mills can be operated but part of the time, and as a consequence, even within the city, there are portions which are daily flooded and daily exposed to the influences of the sun. The exhalations are perceptible to the senses, but without being able to give any precise data on the subject, I cannot recall to my mind any perceptible injurious influence originating from them. The increasing number of sewers and drains emptying into it, however, with privies immediately over its banks would seem to demand that a quick outlet should be insisted upon for their discharge into Connecticut river."

Spring freshets were said to bring "a preponderance of catarrhal affections," followed in May with the arrival of the hot weather by "affections of the mucous membrane of the bowels, near the river."

While the charter and constitution of the new hospital were being drawn up there occurred in the city an epidemic of Asiatic cholera "beyond our expectations." There were about 80 or 90 deaths, possibly more, and mostly among Irish immigrants. This significant note is found in the records: "But two or three only were natives of this country." Here are the various reasons for the epidemic: crowded tenements (in a city of 18,000!), personal uncleanness, imperfect drainage about the dwellings, garbage, filth, privies and pig-sties." And then the triumphal assertion that "It is a matter of congratulation that the city is soon to be supplied with an abundance of pure water, from the Connecticut. . . . The great blessings attending a bountiful supply of pure water to the whole city, will be better appreciated when our citizens become more acquainted with this luxury upon its introduction."

In 1851 the Hartford Medical Society appointed Gurdon W. Russell, Ebenezer K. Hunt and Myron W. Wilson a committee of three to ascertain "what additional accommodations might be needed for the sick and poor of this city." The personnel of this committee changed and no action resulted until, following the boiler explosion, we find the committee of Drs. Russell, Jackson and Hawley reporting progress. The method in which medical services were first provided at the "Home for the Sick" is

of interest. The doctor who first signed the constitution of the Hartford Medical Society was to take charge of this service for a fortnight, and then the next in order, and so on. If prevented from serving he must provide a substitute. On April 2, 1855 the directors of the Hospital requested the Hartford Medical Society to nominate six of their members to constitute a staff for the Hospital. This was done and the following six are listed: Samuel B. Beresford, Gurdon W. Russell, George F. Hawley, Ebenezer K. Hunt, Myron W. Wilson and Ashbel W. Barrows. Dr. Wilson died six months later and David Crary was nominated by the Medical Society to take his place. Of these six the first four, Russell, Hawley, Hunt and Beresford left records which should place them in Hartford's Hall of Fame. Of the four, George Hawley has been rightfully named the Father of the Hartford Hospital.

George Benjamin Hawley was a man of vision but at the same time an indefatigable worker. Largely by his efforts in 1854 an act of incorporation and a conditional grant of money was passed by the Legislature for the establishment of a hospital. To quote his necrologist: "From this time until his death (29 years later), this institution was the first in his thoughts, and absorbed a large share of his attention and energy. From the beginning he was confident of success and labored incessantly with his whole power to this end. Never discouraged by the rebuffs of lukewarmness of those to whom he applied for aid, he was ever ready to present the claims of charity and urge with great earnestness their recognition. Difficulties seemed to have only quickened his zeal and made him more resolute. . . .

"It may well be questioned whether any man with less force could, under the circumstances have brought this enterprise to so successful a termination."

It was George Hawley who selected and purchased the site for the hospital, and it was George Hawley who set out to raise the money for its erection. So convincing was he that there were "few of charitable heart and generous mind" who could resist his appeal, in fact, many made provision for the hospital in their wills. It was George Hawley who superintended the construction of the buildings, with the exception of the women's and children's wards which followed in a few years. He likewise watched with critical interest the expenditure of the funds. He never knew the word failure; his



powers of endurance were seemingly endless and few could accomplish the same amount of work, we are told, in so short a space of time. It was fitting that at the dedication ceremony in 1859 George Hawley should make the principal address. For 28 years he prepared and presented each annual report of the Hospital's executive committee. At the time of his death he was in the midst of securing funds for a home for old people. In addition to a life of devotion to Hartford Hospital George Benjamin Hawley was active in his city, county and State medical societies, was one of four delegates from Connecticut to the American Medical Association in 1861 and the previous year was one of three selected to attend the National Quarantine and Sanitary Convention in Boston. For three quarters of a century a tablet to his memory stood in the doctors' consultation room of the Hospital.

To Samuel B. Beresford the Hartford Hospital owes a large debt of gratitude for his surgical assistance over a period of many years. Born in the torrid climate of Dutch Guiana, Sam Beresford was one of those characters who make history. He never wore flannel undergarments (the custom in those days of Franklin stoves and open sleighs) nor any but low shoes. He was so faithful to his ward patients in the Hospital he often visited them two or even three times a day to the neglect of his private practice. Both Samuel and his father, also a skilled surgeon, were of such large stature that any common chaise of that day was said to have been too lightly constructed to carry both at the same time, so they rode in a heavy four wheeled carriage, apparently of English make.

For his presidential address before the Connecticut Medical Society in 1869, Samuel Beresford chose the subject "Practical Observation on the Abuse of Tobacco and Its Consequences on Health." He denies his interest in the subject as a moral issue, calls it "merely a habit and a bad one, morally and physically considered." "It is also very generally," he continues, "a stern and exacting master when in the ascendancy, holding its victims usually in an unrelaxing grasp to the end—few compared with the vast numbers of its devotees, succeeding when even willing, in completely disentangling themselves from the meshes of its close net." Then he counsels indulgence in moderation, if indeed they must indulge at all, "to affix tubes to their cigars—to select clean new pipes" and to smoke in solitude. Bad enough "to inhale the volatile poisons of your own smoke,

without also receiving those of your neighbors engaged in the same practice." By way of repartee a toast was tendered him at the annual dinner that same evening in the old United States Hotel in Hartford: "Our Retiring President—He floats away gracefully amidst the smoky folds of old Virginia weed."

In his address Dr. Beresford mentions the local congestion of the mucous surfaces of the oral cavity, even ulcerations and "positive malignant conditions" of the cheek and tongue are noted. Effects on the digestive organs, the heart and the glandular system are detailed, but no mention is made of bronchogenic or lung carcinoma. No postmortems of the lungs were readily available in that day.

Realizing the Hospital's debt to this native of the West Indies, a colored memorial window was placed in the Hospital and later moved to the modern structure where it adorns the new chapel.

Gurdon W. Russell found time amid his city, county and State medical society activities to devote to the Hartford Hospital. It has been said that "a history of Dr. Russell's professional life is practically a history of the medical profession of Hartford County" for the seventy years he was active. Gurdon Russell has been characterized as a great counselor, a man of absolutely unselfish honesty, and of sound financial judgment. As president of the Medical Board of the Hospital and also of the corporation, in referring to him the record states that "this institution . . . can never pay the debt it owes to his foresight, sound judgment and untiring energy." In his presidential address before the State Society, being a writer of merit, he gives vent to some of his subconscious fears when he notes the detrimental effects on health of a literary life with its sedentary habits, late hours, derangement of the digestive organs, etc.

Ebenezer Kingsbury Hunt was another one of the founders of and first visiting physicians to the Hartford Hospital. Like some of his fellow staff members, he too served as president of the Connecticut Medical Society and in 1865 as a delegate to the American Medical Association. He is famous in the city annals as the founder of Hartford's water system and is recalled today by each one of us as we enter the home of the Hartford Medical Society, the Hunt Memorial Building.

Lesser lights in the brilliancy of that first group of Visiting Physicians to the Hospital were Ashbel W. Barrows and David Crary. Little can be found

of the latter in medical records but we do know that Dr. Barrows arrived in the presidential chair of the State Society in 1876, having previously served as chairman of a Committee to Recommend Gratuitous Students to the Medical Department of Yale College. His retiring address was on the subject of "Malarial Fevers in New England" and he was bold enough to express the hope "that at no distant day the light of science will reveal and render certain very much which is now only conjecture. Malaria may justly be considered among the greatest evils which affect mankind. Whatever, then, can be done towards checking its progress, allaying its ravages or preventing its development, is worthy of the noblest effort of the physician."

In 1857, shortly after the Hartford Hospital was established in the building of the former Home for the Sick, the Hartford Medical Society presented to the Hospital its library. This, according to Walter R. Steiner, was probably the remainder of the material originally owned by the Hopkins Medical Society together with the books of the Hartford Medical Society. Imagine my amazement to find a recent purchase made from a New York City bookshop to contain inside the cover one printed label with the name Myron W. Wilson and another below which reads

Hartford Hospital  
Medical Library

No. ....

Presented by friends of Dr. Geo. Sumner  
1856

Then on the opposite fly leaf in long hand  
Presented to Dr. Barton  
with the very friendly regards  
of  
The Editor

(The editor in this instance was N. Chapman, M.D.)

The 68th annual convention of the Connecticut Medical Society was convened in Hartford on May 23 and 24, 1860 and for the first time the sessions were held in the Hartford Hospital. You will notice this was a little more than two months before the new building was opened to its first patient. This was in the day when certain members were expelled from the medical guild in Connecticut for breeches of ethics; in one case for "using, vending, and recommending by his publications, his own secret medicines or nostrums;" in another instance for being "notoriously in the practice of Homeopathy, Hydropathy, or any other form of quackery." It

was also the day when "minimum charges—to prevent overcharging" suggested for all the State "except for cities" included "Ordinary obstetrical cases \$4 to \$5; beyond six miles travel extra." "Cupping 50 cents to \$1." "Trephining \$20 to \$30." "Amputations—thigh \$25 to \$50; Leg \$20 to \$40; Arm, Forearm and Breast \$20 to \$30. Small-Pox, or where infection is apprehended, double the usual charge."

Here is an interesting resolution adopted by unanimous vote in 1867 by the Connecticut Medical Society in session at the Hartford Hospital:

"Resolved, That in the opinion of this Convention, whose sessions are held within its walls, the Hartford Hospital, in respect to location, construction and management is admirably adapted to its benevolent purpose:—the care of the sick and suffering among our citizens, and also as a Home for such disabled soldiers of the Commonwealth as may need its aid.

"Resolved, That we earnestly commend it to the favorable notice of the Legislature; believing that in no way can the wants of the classes referred to be suitably supplied at so small a cost to the State, as by granting the aid asked for, to complete the enlargement now in process."

Already more room needed to care for the increased patient load! In the two following years \$86,200 was subscribed by citizens of Hartford, \$20,000 was secured from the State, and the total used to build the south wing, two east wings and a laundry. The bed capacity at that time rose to 100. From then on, as Mrs. Hewes has so well said, "the hospital began to grow like Topsy in all directions" until it was realized a few years ago that the old must be torn down and a new structure erected. Dr. P. M. Hastings must have had the suggestion made to him while he was Supervisor of the Hartford Hospital (1888) that a new plant was needed, for he wrote "An old hospital too good to be taken down must be changed, renovated, modernized, altogether too great a task for a man four score."

In 1891 Dr. W. A. M. Wainwright wrote a paper on "The Proper Care of Seriously Injured Persons" in which he quotes from the records of the Hartford Hospital as follows: "I find that in the past ten years forty-four cases of railroad injuries have died within twenty-four hours after admission: in 1881, two; in 1882, four; in 1883, eight; in 1884, four; in 1885, three; in 1886, four; in 1887, two; in 1888, three; in 1889, seven; in 1890, seven: total, forty-four." He closes his discourse with an appeal for first aid



equipment to be placed in each caboose and each baggage car.

Harmon George Howe was one of the leading surgeons in Hartford at the turn of the century. With the exception of Gurdon W. Russell, Dr. Howe was the only physician to be president of the Hartford Hospital. He was chairman of the Executive Committee for many years and under his directions the Children's Ward, Contagious Ward, and Wildwood Sanatorium were built, also a new kitchen and the Nurses' Home. In addition, Dr. Howe was president of the medical and surgical staff up to the time of his death from an accident in 1913 and for many years he was a member of the Board of Trustees of the Hospital. He published a report in 1897 listing the laparotomies at the Hartford Hospital for the year ending June 30, 1896. By comparison with our present hospital statistics almost 60 years later this report seems well nigh incredible.

Almost 1,700 cases in Hartford Hospital October 1, 1895 to September 30, 1896, inclusive.

500 operations, 76 of the abdominal classified as follows:

DIAGNOSIS	TOTAL CASES	DEATHS
Appendicitis	43	3
Hernia	11	3 (all strangulated)
Nephrotomy	1	1
Fecal fistula	3	0
TB peritonitis	1	0
Sarcoma of omentum	1	1
Psoas abscess	1	0
Ovarian cyst	1	0
Ovarian cyst with hydrosalpinx	1	0
Ovarian cyst, double	1	0
Hysterectomies	4	3
Abdominal abscess	2	0
Adhesion of peritoneum	1	1
Intestinal obstruction	3	2
Exploratory incision	2	0
	76	14

Only one strangulated hernia recovered; nine of the appendectomies recovering had fecal drainage through the operative wound, some for several weeks; all the hysterectomies were done "under urgent necessity."

In 1899 Oliver Cotton Smith was appointed assistant visiting surgeon at Hartford Hospital. Dr. Smith had been heard from eleven years prior to this, however, when he read a paper before the State Society entitled, "Treatment of Urethral Stricture by Elec-

trolysis." He was a skillful surgeon, a leader among his confreres, but he succumbed to a malignancy a few years later while president of the State Medical Society and shortly after receiving an M.A. degree from Yale.

Another surgeon of note was developing at this same time, the seemingly indefatigable Everett J. McKnight, my first surgical chief during my internship. Daddy McKnight was not made of ordinary stuff. From the athletic field at Yale, via general practice in East Hartford, to a place of eminence among his colleagues in Hartford, his interests carried him to the legislative hearings in the State House and on to the Board of Trustees of the American Medical Association which he served as a faithful member. How well some of us can remember him stumping along with his cane, a picture of determination not to be diverted from his purpose! His untiring devotion to duty in the early years of World War I as a member of the American Medical Association Liaison Committee with the National Council of Defense undoubtedly contributed to his unexpected death in December 1916.

This is a fitting place to pause and, with your indulgence, to reminisce a little. Who can ever forget the old brownstone buildings, sprawling out on either side and then turning toward the east in parallel lines, one set housing for the most part medical, the other, surgical patients? Who, if he has attempted to live through an autopsy in February in that scarcely heated outhouse at the far end of the north line of buildings can ever forget the odors, the numbed fingers, and the stiff corpse before him on the old block table? What former intern has forgotten that cozy little hole down a flight of stairs into the underworld near Ward 7 termed the Doctors' Dining Room? And speaking of underworld, it was a rare journey one took by the subterranean route around the circuit from Ward 10 to Ward 5 if one failed to meet up with one or more of those gray, four footed animals with long tails, scampering from hole to hole, reminiscent of scenes in *Les Miserables*! Perhaps it was the enticing odors from the bakery down under Ward 3 corridor which attracted them, but the fresh doughnuts being produced after midnight were worth the gamble if one happened to be en route to or from some sick patient. We must not overlook Peter Metrelis couped up in the little laboratory above the main office building and up half a flight from the intern quarters. That was no airy lab in which to spend a hot August forenoon

doing scores of urinalyses! And then in 1917 the front of the Hospital was lifted, or should I say altered, by the erection of that wartime structure, the Pavilion. It was always having its troubles, either with cracking walls, peeling paint or bursting water pipes. No one wept when it went the way of all the many older buildings to give room for the modern structure we now call the Hartford Hospital.

There were a few of our number who did not live to see our present hospital. Paul Waterman, the distinguished soldier-physician, who did pioneer service in establishing neurology and psychiatry in this city. Ernest A. Wells, the honest surgeon who never let a drop of perspiration falling into a clean operative wound disturb him in the least. In 1922, over 30 years ago, Ernest Wells in reporting on "Recent Progress in Surgery" made some prophetic comments. "There is a present tendency," he wrote, "to lay every physical disability at this door (trauma); so much so that we are in danger of pulling down about our ears the whole mountain of compulsory health insurance, the dust of which avalanche will very nearly blot out forever the whole fee system and from its ashes will arise a new phoenix, the employment of all doctors on a salary basis or by the state. And this, God forbid!

"This much we must face. We are moving rapidly in the direction of the socialization of medicine and of course, of surgery. Witness not only the compensation laws, but the public health services, the welfare work in our industrial plants, the free clinics of all sorts. . . ."

In 1889 a young man by the name of Ansel G. Cook completed his internship at Hartford Hospital. The history of orthopedic surgery in Connecticut is largely synonymous with the story of Dr. Cook's life as they were simultaneous. Orthopedic surgery in our State was profoundly influenced by its course at the Hartford Hospital and no one person contributed more to this than Philip D. Bunce. He served our Hospital for 25 years. Of him it has been said that he "always volunteered to do the holding while the juniors applied the bandages."

Phineas H. Ingalls and Walter R. Steiner may be mentioned in the same breath, since both of these gentlemen used the powers of leadership entrusted to them in guiding the policies of the Hospital for many years. Dr. Ingalls had been essayist for the State Medical Society as far back as 1886 when he

read a discourse on "The Damages of Parturition and Their Repair," and again three years later he discussed "Uterine Cancer," particularly the use of so-called partial and complete surgery for this malady as well as the use of cauterization. He was president of the staff for many years.

Walter R. Steiner has left a name which will always remain outstanding, not only in the history of Hartford Hospital but also in the records of Connecticut medicine. At various times he served as attending pathologist and bacteriologist, attending physician, director of the pathological laboratory, secretary of the Medical and Surgical Staff and later president. Perhaps his greatest contribution was in directing the selection of interns for 25 years. Walter Steiner's history of the Hartford Hospital serves as a valuable reference covering the life of the old hospital.

Then there was William Porter, Eckley R. Storrs, Edward K. Root, and the two Fredericks, Simpson and Crossfield. There was T. Weston Chester, Mark S. Bradley, Charles A. Goodrich, Henry F. Stoll, Frank L. Waite and his brother Robert. The honor roll continues with Arthur C. Heublein, Calvin H. Elliott, Levi B. Cochran, E. Terry Smith, George N. Bell and Alfred M. Rowley. And finally, James H. Birani, Amos T. Harrington, J. Tyree Woodson, Paul P. Swett, John A. Wentworth, John H. T. Sweet, Sidney S. Quarrier and Donald B. Wells.

Paul Swett rose to eminence in his specialty, orthopedic surgery. Loved by all, patients and fellow practitioners, he left an indelible impression of scholarly achievement. His literary accomplishments added much to his prestige in the later years of his life. Descended from a family of bonesetters, John Sweet gave to the science and art of medicine that sterling contribution which comes only from a character of equal worth, namely, honesty. Coupled with this was a sense of humor which made him a delightful companion. John's philosophy of life had its roots in the woods and streams of Connecticut and its heritage in sturdy New England stock.

Sidney S. Quarrier, although with us but a few years, left an enviable record of achievement for a young surgeon. Here again was a man of frank honesty, of conviction, and impelled with a desire to serve. His outstanding contribution to Hartford Hospital was the development of the Saturday morning surgical clinic which, like Cabot's case histories in Boston, became an institution in itself



and stimulated visiting and house staff alike to a frank exchange of opinion based on real scientific study.

On July 6, 1944 Hartford was the scene of a devastating fire which broke out at the Barnum and Bailey circus grounds on Barbour Street. Scores of innocent victims died, many before reaching any hospital. The Municipal, St. Francis and Hartford Hospitals were taxed to the limit. Fortunately for the latter the new South Building had been opened two years previously and it was possible to convert the first floor into a receiving station where the burned victims could be segregated for further treatment. Interested in the treatment of burns for several years, Donald B. Wells soon assumed the leadership in caring for the circus fire victims at the Hartford Hospital. During the fifteen years since he published his beautifully illustrated paper on "The Treatment of Electric Burns," Donald Wells had gained recognition as an authority in this field.

The final chapter in the history of the Hartford Hospital was written when the present modern building was dedicated on March 14, 1948 and opened for the admission of patients 15 days later. The first new complete hospital to be built after the close of World War II, it attracted wide interest from all parts of the world because of its modern

features such as oxygen-making plant, conveyor belts and other labor saving devices. With its new research program and an active staff of 200 physicians this institution should become a progressively improved place for the recovery of patients. The modern hospital of 1954 is a far cry from the institution of 100 years ago where only the very ill were admitted and from whose doors a comparatively small proportion returned to useful lives.

Little has been written of Dr. Nathan Mayer of Hartford but at the centennial celebration of the Hartford County Medical Association in 1892 he read a poem, the product of his own pen, which aptly fits this centennial observance of the Hartford Hospital.

"This day betwixt the past we stand  
And that great time which is to be  
When fruitage comes to all that we  
Have planted with a zealous hand.

"This day we still salute the past,  
We gauge its merit, know its worth,  
Exalt its memories on earth—  
Source of our work, and thus to last.

"But past is past. The age must win  
Its laurels in the future. Fate  
Swings open with the century's gate:  
We enter in—we enter in!"

## INCIDENTS AND ANECDOTES OF THE HARTFORD HOSPITAL

ROBERT A. GOODELL, M.D., *Hartford*

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The Author. *Medical Director, Phoenix Mutual Life Insurance Company, Hartford, Connecticut*

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IN recounting incidents and anecdotes of the Hartford Hospital it is only natural for each of us to think back to his own experience and to the leading physicians he has known. Since my own internship was under the guidance of Dr. A. M. Rowley and Dr. Walter Steiner, many of my remarks will concern these two positive individuals and their contemporaries. We need to know the men and their eccentricities to appreciate fully anecdotes concern-

ing them. Many of you could tell incidents regarding the times and characters related to your own experience and I only wish we had time for such a session.

Dr. A. M. Rowley often told the story of one of the surgeons on Dr. Harmon Howe's service who was supposed to repair a left inguinal hernia but by mistake he operated on the right side. The next day on ward rounds the patient said, "Doctor, I am sore on my right side but my lump is on the left!" "Oh," said the surgeon, "we always do the right side first." The patient was perfectly satisfied and next day had the left side repaired.

*Presented at the Annual Meeting of the Connecticut State Medical Society, Hartford, April 28, 1954*

One of the most amusing incidents in my experience was when Dr. Maxwell Phelps was my junior on A. M. Rowley's service. Max was following the usual procedure of placing sterile towels around the operative field. A. M. was not satisfied with the placement of the towel clips and he was inclined to tap his foot when a bit impatient. After two or three unsatisfactory attempts to place the clip, A. M., tapping his foot, said, "No, doctor, not there but there!" and placed his gloved finger on the exact spot. Max placed the clip in the skin of the anesthetized patient, including A. M.'s unanesthetized finger. A. M.'s comment will not be recorded.

A. M.'s patients were rather sensitive to pain. Often on ward rounds without even a smile Dr. Rowley would enact a little drama. He would lightly put his hand on the abdomen and the patient would say, "Oi!" Then A. M. would tweak the ear. "Oi!" Then the little finger and the little toe—same result—"Oi!" Then A. M. would say, "See, doctor, first day after operation and tender all over."

Dr. Whitfield Larrabee recalls a Greek patient on Dr. Steiner's service. It was important to have a history before ward rounds, but no one could understand. Even Greek help from the kitchen could not talk with the patient. At ward rounds it was explained to Dr. Steiner that no history could be obtained until some of the staff had an opportunity to interview the family. Dr. Steiner said, "I'll handle this. I majored in Greek." Whereupon Dr. Steiner went to the bedside and addressed the patient in Greek. The reply was, "No spek English."

In the first Reports of the Hartford Hospital, 1855-1880, of particular interest are some of the Rules of the Hartford Hospital for Visiting Physicians and Surgeons, particularly in relation to "Government of Patients." Rule number VI, "Spitting on the floor, or other practices inconsistent with neatness, must be avoided." Rule number VII, "No patient shall smoke tobacco in the hospital." Rule number VIII, "Before lying on their beds, patients must take off their boots and shoes." Rule for Admission of Patient, "The ordinary charge per week is \$6, which includes medical and surgical care, together with medicine and nursing." This was double the original price of \$3 per week.

The first surgical records were kept from February 1874 to November 1877. The first surgical patient listed in the record was one, Michael Bradley, age 20, a laborer suffering from a psoas abscess. After treating with poultices for thirteen days, Dr.

Jarvis introduced an aspirator and drew off a pint of pus. On the following day the patient was very weak with respirations hurried and feeble. The treatment was whiskey punch and five grains of quinine every two hours. The next day the patient had a high fever and the abscess had forced an opening through a wound made by the needle of the aspirator. A deep incision was made. On the following day the dose of quinine was reduced to three grains every two hours as the patient complained of ringing in his ears. The patient was given stimulants in "as large quantities as he will take." On June 1, 1874, three months after admission, the patient was discharged cured.

Levi Hamlin was the second surgical patient, a 42 year old farmer wounded during the war, complaining of swollen foot and ankle. "The patient wants his foot amputated." Poultices were applied to the painful and swollen foot and on March 27, 1874, twenty-seven days after admission, the notation was made that the patient had recovered and could walk without a crutch. It was also noted that the patient "makes a good nurse." He was discharged on May 8, over two months later.

Christopher Ryan, a 26 year old teamster from Ireland, was admitted to the hospital complaining of bubo. Pressure was made by keeping a brick over the inflamed gland. The next day the patient complained that he "can't keep the brick on during the night."

Apparently there was no hesitation about spending time and effort in consultation. A lad, age 19, had a fatty tumor of the neck. In consultation were present "Drs. Hawley, Russell, Fuller, Barrows, Hastings, Jarvis, Wainwright, Hudson, Chamberlain, and Dunbar." I wonder if today CMS would approve of ten consultants! The ten names mentioned are prominent in the medical history of Connecticut. Of personal interest to me is the name of Ashbel Ward Barrows, who was the second Medical Director of the Phoenix Mutual Life Insurance Company.

Thomas Gibeony, a 19 year old temperate Connecticut laborer, was admitted with caries of tibia and fibula resulting from an injury "by being run over by horsecar." The disease of the bone was so extensive that amputation was considered the only course of treatment. "Patient didn't want any such operation and left."

The hazards of modern travel were already taking effect. Patrick Slattery, alias McKenna, an intemper-



ate laborer, age 35, was "knocked over the fence by the steam cars." The only serious injury was a fracture of the ulna. Patrick was admitted May 9, 1875, and on June 26 it was noted that there was considerable ankylosis of the elbow. "The man refused to have the adhesions broken up and eloped." The term "eloped" was used fairly commonly when a patient left the hospital against advice.

John Cahill, 50, a temperate laborer from Ireland, was admitted with hemorrhoids. "No treatment except a laxative after which he eloped." Frank Berry of South Windsor was admitted for disfigurement of the face from powder burns. Concentrated acetic acid was applied to each spot and "quite a surface of the face was touched with the acid and a very large scab formed. The patient was afraid that the treatment would be worse than the disease so he eloped October 30 and has not since put in an appearance."

Edward Riley, a 35 year old laborer, was admitted November 7, 1876 with a lacerated wound of the head. "While engaged in an election fight he was struck upon the head with a bottle, making a slight wound on the forehead and rupturing the temporal artery. The wound was drawn together with adhesive plaster." On February 24 he "found out that he was to be discharged so he left at peace with all."

A 30 year old single intemperate teamster was admitted with a diagnosis of frozen feet. Four days later the notation was made, "Feet not frozen. He is a fraud. Discharged."

A 40 year old housekeeper was admitted on the evening of March 12, 1874, "her illness being nervous excitement from intemperate drinking of gin." Nine days later she was discharged—"Her husband wants her home once more."

George Carey, 28, "a single, intemperate, third-rate prize fighter," was admitted because he "burned his leg by exposure to the sun while out clamming at New Haven."

A 66 year old "Connecticut truss and mesh-net manufacturer, married, sober, temperate in all things," was admitted in December 1874. It must be that his character somewhat changed while he was in the hospital for a few days later he was "discharged for disorderly conduct."

A butcher was admitted November 8, 1875 with retention of urine from stricture. Sounds were passed

every other day for dilation of stricture. On November 10 two wax bougies and number 6 steel sound were passed. On November 15 "succeeded in passing the largest wax bougie." Fifteen days after admission the patient was "discharged happy and has gone into the sausage business with renewed vigor."

Margaret Dunn, who was injured ten years previously, was admitted on February 9, 1872, having lost the power of both limbs one and a half years before admission. The treatment in February consisted of tonics. By July the treatment was interestingly changed to "electricity." In September she was gaining the use of her limbs very slowly. By December she could walk a little with assistance. In September 1874, one year after the start of treatment with electricity, she "walks easily. Goes out to church."

On December 10, 1873, Patrick Brennan was admitted. "Has wind in his stomach and is a soldier."

A 67 year old leather dresser was admitted with senile debility, having the appearance of having had apoplexy some time ago. On examination of his urine a little sugar was found. Twelve days later he was "improving steadily on tonic treatment." Ten days later friends sent him a feather bed—"a cruel kindness." After another ten days the note is made that "he lies on his back in feathers and is getting a bed sore and atrophy of gluteal muscles. Insisted on his getting up." After leaving his feather bed he steadily got better and was discharged improved.

A 37 year old housekeeper was admitted with ascites. She had been tapped several times and seemed to be improving. A month later, "had some trouble with her spouse, who refuses to pay any more money for her bread and hash here, so she is discharged—improved."

Bridget Connor, a 55 year old housekeeper, was admitted in December 1873 with hemiplegia and "alcoholismus." A week later a Christmas wreath took fire near the head of her bed which so startled her as to make her, for the time, unaware of her hemiplegia. Dr. Jarvis asked, "Why in the dominion of his Satanic Majesty don't you have another fire?"

On January 1, 1874 Thomas Steele, age 47, was admitted suffering from his fifth attack of gout. He was treated with wine of colchicum and carbonate of potash. On January 5, much better. "Think a nice chop would agree with his stomach." On January 10, discharged, cured. "Has gone for his nice chops."

A 39 year old laborer was admitted with "rheumatism and a wooden leg." He had taken a large amount of poor whiskey. Seven "fly blisters, one times one, were ordered over the sciatic nerve." He pulled off the blisters during the night. Fourteen more were applied "on rump and leg. Patient pulled them off at 12 M. when he was discharged cured."

In February, 1874 a 29 year old laborer was admitted with lumbago. He received the usual treatment of blisters. Twelve days later the notation was made, "William says he is disabled and wants to get into the Soldiers' Home. Although he swears to great disability, still he is strong enough to eat and sleep well." In March he was discharged. "Has gone on his way rejoicing to the home."

In May, 1874 a 30 year old housewife was admitted and "delivered of a fine boy." Thirteen days later, "Katie has this evening a very severe headache. Morphia sulph. has been administered and we await results." The next day, "Katie kindly yielded to treatment, and tired nature's sweet restorer, balmy sleep, engulfed her in his somniferous mantle. In the early matin hours she awoke to things terrestrial, refreshed and invigorated, and when the frugal meal was prepared she destroyed her usual hash."

Ninety years ago this month a 30 year old quarryman was admitted to the surgical ward. Twelve days later he was transferred to the medical ward with mitral insufficiency. Six days later he took his departure. "Being an untamed child of nature he sought those paths where he could travel both sides of the road unmolested." It was a good thing he did not drive away in an automobile.

A 25 year old male was admitted in May, 1874, diagnosis not recorded. Five days later the notation was made, "Feels much better and looks brighter. He is confident that whiskey and water (nine parts of spirits fermenti to one of aqua) would be efficacious in the ills to which his flesh is heir." Pepsin and bicarbonate of potassium were given and a month later he was discharged improved.

A 40 year old "temperate" laborer was admitted in November, 1874 with gastritis from abuse of whiskey. On December 31, 1874 the following notation was made: "After wrestling unsuccessfully with the accompaniments of Christmas, Michael returned to the hospital much the worse for the conflict."

On November 27, 1874 a 16 year old colored, temperate, single, domestic was admitted to the hospital. She says she has "manners, religion, and fits.

Got the manners and piety in North Carolina; doesn't know where the fits came from. Gave her potassium bromide 20 grains t.i.d. without controlling the fits which were, however, decreased in severity by a hot capsicum footbath." On December 13 Dr. Wainwright ordered 8 grains ammonium bromide t.i.d. in addition to the potassium bromide. There was no improvement.

Looking back at more recent times, the prohibition era produced many amusing incidents. One of the now retired members of the staff went to a New England village and felt he needed something to take "on a fishing trip." He asked a native resident if there was any place in town where one could buy a bottle. The reply was, "You see that millinery shop up the street?" "Yes, but you can't buy liquor in a millinery shop." "I know it, but that's the only place in town you can't buy it."

There are many stories concerning Dr. Ansel G. Cook. When an intern, he was on the witness stand regarding some legal matter concerning a patient. An attorney was trying to heckle and confuse the young doctor. The lawyer said, "Now, Dr. Cook, you say on such and such a day these things happened. How do you know all this took place?" Ansel calmly replied, "By a certain peculiar mental process known as 'memory'!" Ansel G. Cook was one of the first to own an automobile. Dr. McKnight was admiring the new machine and wondering just how it worked. "Why, very simple," said Ansel, lifting the hood. "You see, that pipe is where you put in the gasoline. Now come around back and you see this pipe is where it comes out. That's all there is to it."

Dr. Isaac Kingsbury recalls a Mrs. Bean he had admitted for gall bladder surgery. She was seen by three surgeons, namely, Drs. Ingalls, Ansel G. Cook, and "Whiskers" Root. These consultants appeared as large men with formidable mustaches and in one case a "duster" type beard. Leaning over the patient, one physician said, "I think we should make the incision from here to here." "No," another said, "it should be from here to here." Later in the day Dr. Kingsley found that Mrs. Bean had left the hospital. He went to her home and asked what had happened. The patient replied, "When they said cut from here to here or maybe from here to here, I said, 'Beany, home is the place for me!'"

Another retired Hartford Hospital staff member recalls the early days when he had climbed three long flights of stairs to see a spinster with some chest



condition. He then discovered he had left his stethoscope in his buggy. At that time medical schools taught direct auscultation as well as the use of a stethoscope. Rather than climb the stairs again the physician used the direct method on the small area the spinster would expose. When he had finished, the patient with a coy smile exposed the other side. "Doctor, don't you want to warm the other ear?"

In more recent times there was a house officer who had a habit of going to the old OB ward about 11 each night and getting the nurses to mix him a milkshake. Somewhat tired of this, one night the nurse used breast milk. After he had downed the milkshake, the nurse asked the house officer how he liked it and he said, "Fine." The nurse then told him the source of the milk and he promptly lost his milkshake.

We perhaps should not turn away from former days without giving a pat on the head to the iron dog which today guards the entrance to the new hospital. This one hundred fifty pound faithful guardian was presented to the hospital by "Uncle Billie" Morgan, probably in the 1890's. The dog originally rested by the ambulance entrance to the hospital; later it was placed by the Hall Wilson Laboratory. Since interns formerly had few nights off and had to provide their own amusement, the iron dog has more than once rested on the bed of some intern lucky enough to get an evening away from the hospital. This house officer on return to his room in the early hours would have to struggle with our one hundred fifty pound friend or sleep with him. At times the dog has been painted various colors which meant that the maintenance department had to remove the paint. Tiring of removing paint and returning the dog to his proper place, the department finally stored him in the basement. Here he was spied by two students of Manhattan College who were calling on two student nurses. The iron dog took his longest journey since the gay nineties. One of the nurses told a Hartford Hospital official who contacted Manhattan College and the dog was returned. Now the iron dog is securely fastened in concrete by the entrance to the hospital and may be admired by all. Children love him. Mysterious persons tie ribbons around his neck, always a red ribbon at Christmas and a green ribbon on St. Patrick's day. As I write this he has a purple ribbon

placed there by some unknown admirer. Other dogs befriend him and pay him compliments which unfortunately he cannot return since his feet are in concrete. What can be a better link with the gay and amusing past than this handsome and imposing friend, the iron dog?

### Dean Lippard Named President of Association of American Medical Colleges

Dr. Vernon W. Lippard, dean of the Yale University School of Medicine, was installed as president of the Association of American Medical Colleges at the association's recent annual meeting.

The meeting, held at French Lick, Indiana, was attended by representatives from medical schools in the United States, Canada and the Philippines. Dr. Lippard succeeds Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, who has served as president of the association during the past year.

## THE DOCTOR'S OFFICE

Robert C. Emmel, M.D. announces the removal of his office for the practice of obstetrics and gynecology to 1005 Farmington Avenue Plaza, West Hartford.

Robert G. Reynolds, M.D. announces the association of Harry R. Gossling, M.D. with him in the practice of orthopedic surgery at 85 Jefferson Street, Hartford.

Robert W. Shreve, M.D. announces the removal of his office for the practice of obstetrics and gynecology to 1005 Farmington Avenue Plaza, West Hartford.

William Beecher Scoville, M.D., Benjamin Bradford Whitcomb, M.D., Rembrandt Harvey Dunsmore, M.D. announce the association of Francis George Reilly, M.D. in the practice of neurological surgery.

C. F. Von Salzen, M.D. announces the association of James M. Trench, M.D. in the practice of psychiatry at 725 Asylum Avenue, Hartford.

## Special Article

### AUTOMOTIVE CRASH INJURY RESEARCH IN CONNECTICUT

ROBERT M. TRACY, *New York City*

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The Author. *Field Representative, Cornell Auto Crash Injury Research*

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THE Connecticut-Cornell Automotive Crash Injury Research project has been in progress for five months. In two sampling areas, the first centered at Stafford Springs and the second at New London, physicians and hospital personnel are collaborating with State police in a special study of the causes of injuries to the occupants of passenger automobiles involved in accidents. The Connecticut study is part of an interstate project supervised by Cornell University Medical College. Other participating States are Maryland, North Carolina, and Virginia. Plans for the inclusion of Minnesota are also under consideration and arrangements have been made to obtain the first urban sampling of crash injuries from the City of Minneapolis.

This interstate project promises to produce, for the first time, information concerning the specific causes of injuries and deaths in a representative sample of passenger car accidents. The study is aimed at producing statistically reliable facts which will be useful to the automobile manufacturers in their efforts to design passenger cars which will offer better protection to occupants when accidents happen. Preliminary findings of the interstate project resulting from the first year's work show promise that the study will yield good results. Automobile manufacturers, medical, insurance and safety groups are following its progress closely and it would appear that ultimately this research effort may well affect everyone who rides in a passenger car. In this important activity Connecticut physicians play an important role.

It is interesting to note that this effort to produce safer cars, which at first glance would appear to fall more properly in the category of engineering, has been undertaken by a medical group. The point of view adopted by Cornell and by cooperating agencies is that the widespread incidence of passenger car-accident injuries represents a medical problem

of epidemic proportions. The Cornell project functions under the Department of Public Health and Preventive Medicine of the Medical College and is sponsored by the Commission on Accidental Trauma of the Armed Forces Epidemiological Board and is supported by funds provided by the Surgeon General, Department of the Army. For the purposes of this study, impact injury in passenger automobiles is considered a present-day endemic situation as characteristic of our times as were the widespread occurrences of typhoid or malaria fevers in the days before medical groups found, through research, means of coping with them. Toward the solution of this new medical problem it is believed that many of the classic research methods, successful in the past, can be of equal value.

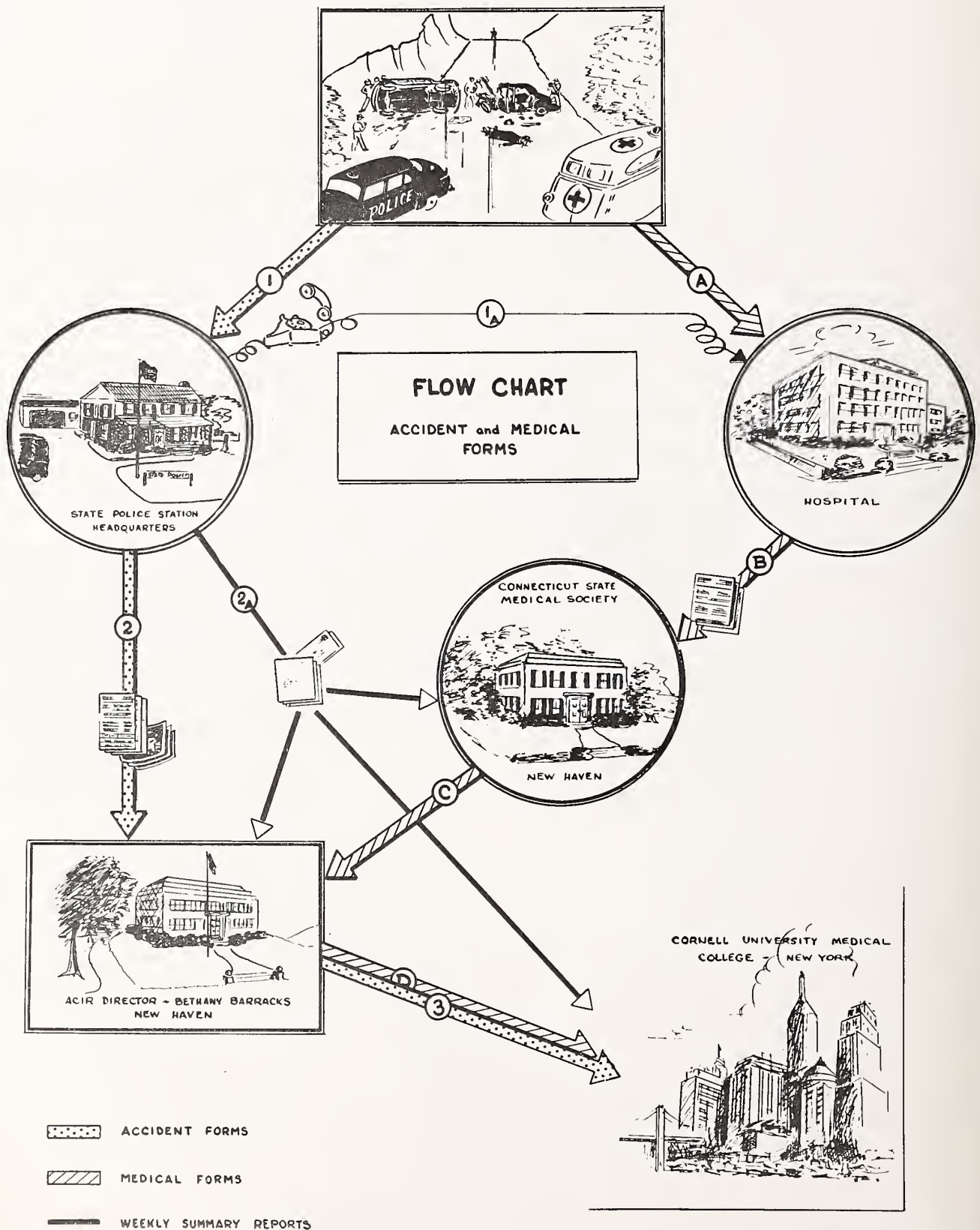
Because no systematized records previously were kept of the causes of injury in passenger car accidents or, for that matter, of the nature of the injuries themselves, an entirely new data-collecting system has been set up which functions parallel to already existing record keeping procedures. Without reliable and detailed information such as is being currently recorded by physicians and State police in cooperating States, it is not believed that this disease of impact injury on the highways can be successfully attacked.

In the carefully selected sampling areas where the study is going on, specially trained State troopers record on a separate form detailed information concerning the type of accident, the resulting damage to the car and the seated position of all occupants. On a section of the form concerning injuries, the investigating trooper records the objects in the car which, in his opinion, caused the damage to the body areas of the driver and passengers. Photographs of auto damage details and close-ups of injury-producing objects are also taken. To complete the case, the attending physician fills out a special form for each injured person describing the precise nature and extent of all injuries.

In all cooperating States the study is attempted only after the approval of State and local medical



# CONNECTICUT-CORNELL AUTO CRASH INJURY RESEARCH



societies has been granted, key physicians briefed, and hospital administrators and their accident room personnel alerted to the needs of the study. State police working on the project are given intensive training and the entire program is closely coordinated by Cornell in an attempt to produce information which will be statistically reliable.

Medical aspects of the Connecticut study are supervised by a Medical Society Committee consisting of Dr. Harold A. Bergendahl, Norwich, chairman; Dr. Paul W. Vestal, New Haven; Dr. George Crawford, Centerbrook; Dr. Brae Rafferty of Willimantic and Dr. Creighton Barker of New Haven. A system has been established whereby hospital personnel are notified by State police which accident victims come under the scope of the study. Completed medical forms are forwarded to the Crash Injury Research Committee at the Connecticut Medical Society Headquarters in New Haven for review, after which they are matched with the associated accident forms and photographs and sent to Cornell. Completed cases are analyzed by Cornell personnel and the information coded and transcribed onto IBM punch cards for statistical use.

In presenting the fundamentals of crash-injury research, members of the Cornell group often refer to what they term the "packaging" concept. For the purpose of illustration, occupants of an automobile traveling down the highway are regarded as "valuable goods in transit" and the automobile as a "package" containing these goods. Automotive Crash Injury Research is a systematized evaluation of the integrity of this package. It is pointed out that fragile objects are not shipped from one place to another unless properly packaged, i.e., unless the structures of the package are strong enough to withstand tumbling or rough use and unless the fragile object is protected from smashing against unyielding sides of the package by padding or by tying down or both. In this respect it almost can be said that greater care is given to the packaging of a fifty cent vase than to the infinitely more valuable contents of the package represented by our present day automobile.

Although the volume of Connecticut cases is not yet sufficient for statistical use, trends based upon an examination of 360 cases involving 863 injured persons from other States, which have been longer in the program, have furnished some interesting evaluations of the passenger automobile as a package. In some respects our automobiles are offering

a good protection to occupants during accidents. In a surprising number of accidents involving severe deceleration forces, drivers and passengers emerge with minor or no injury despite steering wheels bent by chest impact, instrument panels dented by body impact, and windshields cracked or broken by heads.

Highlighting the need for improvements in design, however, are doors which open during accidents resulting in the subjection of occupants to increased hazard when they are violently ejected through open doorways into the path of other vehicles or onto unyielding pavements. Using the data-gathering techniques described earlier, a study of the opening of front doors during accidents was completed. It was found that in those injury-producing accidents examined by Cornell, one or more front doors opened in nonrollover accidents 52 per cent of the time. Rollover accidents in which this phenomena occurred 77 per cent of the time highlight the danger even further. When one or more doors opened, the occurrence of occupant ejection was 34 per cent. And, most significant of all, was the finding that the occurrence of moderate to fatal injury doubled when people were thrown out. Although these percentages may be slightly altered as the volume of data grows, it is not believed that the trend will be significantly changed.

Next in frequency to ejection as a cause of injury was the instrument panel, followed closely by the windshield frame or glass, components of the steering mechanism, and door structures and associated hardware. Further runs on the IBM machines with a larger volume of cases will break down into detail numerous injury-producing objects such as steering wheel rims, hubs or spokes, instrument panel fittings, glareshield attachment fittings, rearview mirrors, etc.

Concerning the relative danger of different seated positions, an interesting finding has shown up which is contrary to popular belief. Exposure to moderate through fatal injury of right front seat passengers was not found to be significantly greater than that of drivers. In other words, popular references to the right front seat position as the "suicide seat" have probably been in error. As would be expected, the safest place in a passenger car is the rear seat. Exposure to injury by occupants in this position was over three times less than that of driver and front seat passengers.

Perhaps of greatest interest to doctors, however,



is information concerning injuries themselves. Here again some rather surprising finding have appeared. The low percentage of injuries to the neck and cervical spine is encouraging in that the occurrence of broken necks apparently is nowhere near as frequent as had been suspected. Injuries to specific body areas are ranked as follows:

#### INJURIES TO SPECIFIC BODY AREAS

INJURY TO	NORTH CAROLINA	MARYLAND
Head	73%	80%
Neck and cervical spine	7%	2%
Thorax and thoracic spine	33%	30%
Abdomen—pelvis and lumbar spine	13%	11%
Upper extremities	26%	22%
Lower extremities	50%	50%

The code used by Cornell in recording injuries for the IBM system permits the keeping of the records concerning the nature and extent of injuries in great detail. As the study progresses, doctors will be particularly interested in detailed information concerning such traumatic effects of accidents as the incidence, type and degree of internal injuries associated with impact on steering wheels, the frequency of mild, moderate, or severe concussion associated with head injury, the frequency of fractured skulls, cervical vertebrae, lumbar vertebrae, dislocations of the femur, fractures of the pelvis, etc. It is expected that detailed information on the percentages of disfiguring and disabling injuries will be also forthcoming. As can be readily seen, this body of data will be interesting not only to physicians, but also to casualty underwriters.

Physicians actively cooperating in the study and those who will, doubtless, be participating in the future when the sampling areas are moved, are urged to remember that for the purposes of this project the recording of each injury, however slight, is important. It will be readily appreciated that a contused forehead caused by impact on an instrument panel knob in a fifteen mile an hour collision might well be a severe concussion at thirty miles an hour and a fatal penetrating fracture at fifty-five. Therefore, the recording of minor injuries is of great significance in that each case adds weight to the evidence needed to convict the killer items. Following this line of reasoning, the importance of carefully detailing the occurrence of multiple fatal lesions will be readily perceived. Of great value also is the inclusion of the doctor's prognosis concerning injuries

which might result in permanent disfigurement or disability.

The Cornell forms are brief, generally requiring less than five minutes time. In this effort to reduce the epidemic proportions of our present day disease of impact injury, doctors are urged wholeheartedly to cooperate.

### Prophylaxis Program of Connecticut Heart Association

The initial meeting of a state-wide planning committee to discuss details for a Rheumatic Fever Prophylaxis Program for Connecticut was recently held in Hartford. Representatives of the Connecticut Pharmaceutical Association, retail and wholesale druggists, the Connecticut Medical Society and the Connecticut Heart Association carried on exploratory talks to clarify possible procedures to be established concerning the securing of prophylactic drugs. As a result of this extremely productive meeting during which considerable progress was made a sound foundation has been established. This planning committee voted to continue functioning as a working committee to carry through the program.

### '53 CV Disease Toll More Than All Others Combined

Heart and blood vessel diseases continue to take more American lives than all other causes of death combined, according to figures recently released for 1953 by the National Office of Vital Statistics. Following is a detailed breakdown for the first five leading causes of death:

CAUSE	NUMBER	PER CENT OF
		DEATHS FROM ALL CAUSES
Cardiovascular diseases .....	794,120	52.3
Malignant neoplasms (cancer) .....	229,110	15.1
Accidents .....	93,200	6.1
Pneumonia .....	52,230	3.4
Diabetes .....	25,390	1.7

### A Snort for Father

The latest request received in one of our hospitals from the group of expectant fathers is for a snort for the fathers to make his anxious, waiting moments more endurable.

## The 17th International Congress of Ophthalmology

The 17th International Congress of Ophthalmology opened Friday, September 10 in Montreal, Canada. On Sunday the 12th it moved to New York. It was closed on Friday the 17th.

The scientific papers covered almost every field in ophthalmology. Among the most striking was a panel discussion on "Retrolental Fibroplasia" in which the unanimous opinion was that the exposure of prematurely born infants to oxygen is the main cause of retrolental fibroplasia. "Oxygen weaning" reduces the incidence of retinopathy of prematurity.

From Russia came the report of 7,500 operations for corneal transplantation with a percentage of success between seventy-five and ninety, favorable for this procedure.

The French "Dr. Dollfus" reports about 1,300 diabetic patients. Statistics show that 70 per cent of diabetic patients are free of ocular complications when they are over forty-five years of age. Furthermore, the duration of diabetes is the main point and the only one which is valid. In cases of diabetes which is over fifteen years old, 80 per cent of the cases have retinal lesions.

Dr. Boeder of the American Ophthalmology Company read a very interesting paper on space perception.

The discussions on virus diseases of the eye were concentrated on trachoma and Behcet's disease.

As far as the survey for retinal detachment is concerned interest was concentrated on surgery for shortening of the eyeball. It also seems possible to shorten the time of the duration of the patient's stay in the hospital.

Dr. Spaeth gave a most interesting talk on surgery of the vertical in the horizontal concomitant strabismus, by analyzing over 1,000 squint operations performed by him in four years. A series of articles on glaucoma and a symposium on the medial of the eye were interesting.

Important also, were a series of articles on the vitreous body from the Retina Foundation in Boston (Dr. Schepens).

Representatives of all countries of the world were

present. Outside the scientific ophthalmological papers there were various activities offered. On Friday the 10th there was an opening ceremony where the various representatives of universities were present in academic dress. On occasion of this opening ceremony the Gonin Medal was presented to Sir Stewart Duke-Elder by the president, Dr. Bernard Samuels, who managed skillfully to keep everything on schedule during the whole session. This was followed by a luncheon given by the University of Montreal. This new French-speaking Catholic university is beautifully located on top of a hill. In the afternoon there was a meeting of the International Councils Against Trachoma. Tea was served to the ladies, and at 6:30 a cocktail party with buffet supper given by the Mayor of Montreal. On Saturday excursions were provided for visiting the town and surrounding countryside.

In New York the Congress was located in the Waldorf Astoria Hotel. It provided ample facilities. On Sunday night Miss Ida Mann, the world's authority on the embryology of the eye who after the war moved from England to Australia, gave a most interesting and enjoyable lecture on her "Journey To The Never Never." She made a survey on behalf of the government of Australia of the eye diseases in far remote places of this part of the world among the aborigines. On Monday there was a cruise around Manhattan by yacht. On Wednesday there was a luncheon and fashion show for the ladies. On Thursday a Congress banquet.

Every afternoon there were surgical clinics that were televised in color from various studios in New York to the Waldorf Astoria Hotel, courtesy of Smith, Kline & French. This program was beautifully organized by Dr. F. Brittain Payne and drew an overwhelming number of spectators to such an extent that the attendance at the papers, which were read simultaneously, suffered badly. It also affected severely the attendance of the scientific exhibits which were most interesting and on which a great deal of time and effort had been spent.

The 17th International Congress of Ophthalmology was well attended and in many respects a great success.

Peripateticus



## NEWS FROM WASHINGTON

### Four Physicians Returned to House, Two Defeated

Four of five incumbent physician-members of the House have won re-election—Drs. Ivor D. Fenton (R—Pennsylvania), Thomas E. Morgan (D—Pennsylvania), A. L. Miller (R—Nebraska) and Walter H. Judd (R—Minnesota). A fifth, Dr. Will Neal (R—West Virginia) lost out in a bid for a second term to M. G. Burnside, a former member of Congress. Rear Admiral Ross T. McIntire, personal physician to the late President Franklin Roosevelt and one time medical director of the American Red Cross, failed in his first bid for a Congressional seat. He was defeated by incumbent Bob Wilson (R—California). Dr. McIntire ran on the Democratic ticket.

### What Election Results Mean in Committee Realignments

This year's election will result in a shift in chairmanships of all House and Senate Committees. Democrats in line for chairmanships generally are the same men who presided during the last Democratic Congress, 1951-52, but the two committees most important in medical legislation are notable exceptions:

The House Interstate and Foreign Commerce Committee chairman will be J. Percy Priest of Tennessee, replacing Charles Wolverton of New Jersey. Mr. Priest was the House Majority Whip in 1951-52 and for a time chairman of the Interstate and Foreign Commerce Committee's Health subcommittee. Mr. Priest moves up to chairmanship of the full committee because former chairman Democratic Robert Crosser has retired from Congress. This committee handles most medical legislation.

The Senate Labor and Welfare Committee will be presided over by Senator Lister Hill of Alabama, replacing William Purtell of Connecticut. Senator James E. Murray, chairman of the committee in the Democratic 82nd Congress, again would be entitled to the post, but has decided instead to take the chairmanship of the Interior and Insular Affairs Committee. Like Mr. Priest, Senator Hill has been interested in health legislation. He was co-sponsor of

the Hill-Burton hospital construction legislation passed in 1947.

Other Senate Committees important in medical and allied legislation are expected to show these changes:

Appropriations—Carl Hayden of Arizona to take the chairmanship, replacing Styles Bridges of New Hampshire. Armed Services—Richard B. Russell to replace Leverett Saltonstall of Massachusetts. Banking and Currency—J. W. Fulbright of Arkansas replacing Homer E. Capehart of Indiana. Government Operations—John L. McClellan of Arkansas replacing Joseph R. McCarthy of Wisconsin. Interstate and Foreign Commerce—Warren G. Magnuson of Washington replacing John W. Bricker of Ohio. Judiciary—Harley M. Kilgore of West Virginia replacing William Langer of North Dakota. (At this writing the Democrats, with the support of Independent Wayne Morse of Oregon, have a clear-cut margin of two votes in the Senate. There is a slight possibility that the Democrats will not want to organize the Senate when the defection of one member could give the Republicans control.)

Other changes in House Committees which will handle legislation of interest to the medical profession are expected to include:

Appropriations—Clarence Cannon of Missouri replacing John Taber of New York. Armed Services—Carl Vinson of Georgia replacing Dewey Short of Missouri. Education and Labor—Graham A. Barden of North Carolina replacing Samuel K. McConnell, Jr., of Pennsylvania. Government Operations—William L. Dawson of Illinois replacing Clare E. Hoffman of Michigan. Interior and Insular Affairs—Clair Engle of California replacing A. L. Miller of Nebraska. Judiciary—Emmanuel Celler of New York replacing Chauncey W. Reed of Illinois. Veterans Affairs—Olin E. Teague replacing Edith Nourse Rogers of Massachusetts. Ways and Means—Jere Cooper replacing Daniel A. Reed of New York.

### 400,000 Nurses Now On Duty

Almost 400,000 nurses now are on active duty in the United States, an increase of 16,000 in five years, according to a Public Health Service survey. The estimate shows the following: 231,000 hospital

nurses, a 15 per cent increase in four years; 74,000 private duty nurses; 35,200 nurses working in physicians' offices; 25,300 public health nurses; 14,000 industrial nurses; 8,200 nurse educators and 1,900 in a variety of other fields. Although the ratio of nursing personnel to patients is at an all-time peak, 74 per 100, Surgeon General Scheele said the need for nurses justified the present annual student nurse recruitment goal of 55,000.

### **Mrs. Hobby Presses Reinsurance at Life Insurance Convention**

Secretary Hobby is continuing to press for enactment of the federal reinsurance program defeated in the last Congress. Her latest activity was at the American Life Convention meeting in Chicago, where she devoted a large part of her talk to this subject. Mrs. Hobby said the administration is backing reinsurance because ". . . time is running against those who seek to keep health insurance on a voluntary basis." She added: "We still strongly believe in a bill . . . which seeks to compress the experimentation of the next 20 years into less than half the time through the simple mechanism of a broad sharing of risks. We believe such a bill will . . . nurture rather than weaken the voluntary health insurance concept."

The American Medical Association opposes reinsurance on the grounds that (a) the insurance carriers themselves have all the reinsurance money needed, (b) voluntary health insurance is making "extremely rapid" progress without reinsurance, (c) reinsurance would not make uninsurable risks insurable, and (d) without an objectionable subsidy reinsurance would not reduce the cost of insurance or "overcome the inertia of the unwilling buyer."

### **FTC Files Complaints Against Health Insurance Groups**

The Federal Trade Commission on October 19 filed formal charges accusing 17 insurance companies for false and misleading advertising of health and accident plans through misrepresentation of their policies. Immediately the Joint Committee on Health Insurance, representing the industry, issued a statement emphasizing that the complaints were not a definite finding or ruling. The statement also said that the government's action should not be interpreted as evidence "that the relatively few companies involved are averse to changing their advertising to remove FTC objections."

In the event the government's charges are sustained by the full committee following hearings, the FTC will issue cease-and-desist orders, requiring the companies to alter their advertising to comply with the orders. FTC estimates that the 17 companies account for about a third of the individual accident and health policies in existence in the United States.

Some of the misrepresentations alleged by FTC include: (1) Extent of coverage—Many policies will not pay at all for losses due to such things as nervous disorders, or pregnancy; nor for hernia and heart disease unless originating six months after policy date, nor for sickness traceable to preexisting conditions. (2) Maximum dollar limits—Many policies provide full payment only for one or two comparatively rare operations; maximum average payable is one-fourth of the specified amount or even less. (3) Starting time of coverage—Certain companies represent coverage at effective policy date, although coverage begins after a specified period. (4) Health status of applicant—Certain companies state no medical exams are required to obtain policies when actually policies don't cover preexisting conditions.

FTC listed the companies and locations as follows: American Hospital and Life, San Antonio; American Life and Accident, St. Louis; Automobile Owners Safety, Kansas City, Missouri; Bankers Life and Casualty, Chicago; Commercial Travelers, Salt Lake City; Commercial Travelers Mutual Accident, Utica; Guarantee Reserve Life, Chicago; Illinois Commercial Men's Association, Chicago; LaSalle Casualty Co., Chicago; Life Insurance Co. of America and its officers, Wilmington, Delaware; Mutual Benefit Health and Accident Association (Mutual of Omaha), Omaha; Prudence Life, Chicago; Reserve Life, Dallas; Southern National, Little Rock, Arkansas; Travelers Health Association, Omaha; and United Insurance, Chicago.

The Joint Committee's statement, issued on behalf of all health insurance companies, declared in part: "The accident and health insurance business has cooperated fully with the . . . Commission . . . in its inquiry into the advertising of companies issuing accident and health insurance. . . . The complaints of course do not constitute a criticism of the advertising literature of the business as a whole. Nor should they be interpreted as criticism of the accident and health insurance contracts issued by any of the companies. . . . The advertising codes recently established . . . provide advertising ethics and practices that reflect clearly the desire of their members to follow the highest stand-



ards. Compliance . . . should assure advertising that meets those standards."

### German Physicians Living in U. S. Now Subject to Doctor Draft

Physicians who are nationals of Germany and have been admitted to this country for permanent residence must now register under the Doctor Draft Act. Selective Service headquarters said the requirement applies to those doctors who had not yet reached their 50th birthday on January 15, 1951. However, the prohibition against calling of any physician 51 years or older for service will apply to German nationals too. Selective Service action stems from the expiration of a provision in a pre-World War II U. S.-German treaty exempting nationals of each country from military service while living in the other country. No official estimate of the number of physicians, dentists or veterinarians affected by the order was available, but it is certain to run into the thousands.

The U. S. has treaties or international agreements with 17 other countries containing reciprocal provisions of exemption from military duty. They are Argentina, Austria, Costa Rica, China, El Salvador, Estonia, Honduras, Ireland, Italy, Latvia, Liberia, Norway, Paraguay, Spain, Switzerland, Thailand, and Yugoslavia.

Under terms of the Doctor Draft Act amendment of June, 1953, the way was cleared for drafting of aliens. The law states that a registrant under the act is no longer held ineligible for appointment as an officer on the sole ground he is not a citizen of the U. S. or has not made a declaration of intent to become a citizen.

### Biggest Draft Call for Doctors Being Prepared

White House is being asked to approve a January draft call for physicians and dentists that is expected to be the largest to date. All three armed services have put in requisitions, which have been okayed by medical advisory committee to Selective Service and forwarded to President for final approval. Draft boards throughout country are now trying to fill December quotas, which call for 550 physicians and 429 dentists. It is quite possible that forthcoming January callup will be the finale under provisions of doctor draft law.

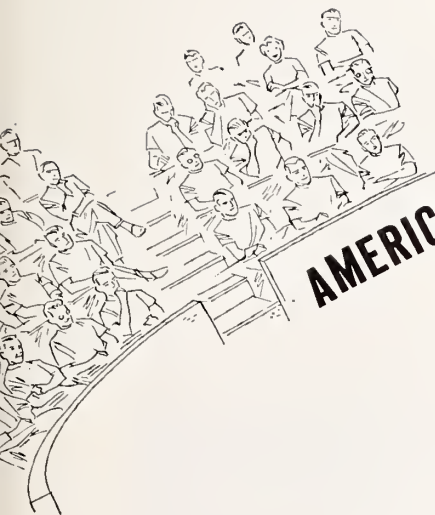
### Defense Studies Continuation of \$100 Equalization Pay

Among legislative proposals under study by Defense Department is continuation of the \$100 a month additional pay for physicians and dentists coming into the services under the new medical officer commissioning program after next June. The bonus pay provision is part of the Doctor Draft Act which is slated to expire next June 30. As now contemplated, this extra pay would be applied only to those physicians and dentists who sign up for more than the minimum two years. This would be in line with the Strauss Commission report of March, 1953, on pay for the armed forces. It advocated the \$100 be limited to doctors willing to serve on a career basis or for periods of duty longer than required of citizens generally. Those on active duty June 30, however, will continue to receive the \$100.

Meanwhile, Defense reports that about 1,900 non-veteran physicians who will complete their internships next June have indicated interest in the new commissioning program. Of these, about 1,325 asked consideration for residency deferments. The remaining 525 said they would be ready to take commissions and go on active duty some time after June. An as yet undermined number of the 1,325 will be given deferments by lot, results of which are to be announced in early December.

### Medical Council Named to Advise Army On Reserves

Army Surgeon General George E. Armstrong has announced formation of a council of five general officers from the Army Medical Corps Reserve. The council will advise him on special reserve matters "having far reaching impact on the health professions of the nation as well as on those problems concerning the general activities of the Army's medical reserve." It will meet each spring and fall on such problems as procurement of reserve personnel, utilization of professional reserves, and promotion of closer relationship between military and civilian medicine. Members are Brig. Gens. Perrin H. Long, College of Medicine, State University of New York; Alexander Marble, Joslin Clinic, Boston; I. S. Ravdin, University of Pennsylvania School of Medicine; Harold G. Scheie, University of Pennsylvania Graduate School, and Frank E. Wilson, director of the AMA's Washington Office.



**AMERICAN MEDICAL**



**EDUCATION FOUNDATION**

*Connecticut Committee*  
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**A REMINDER:**

THERE STILL IS TIME TO CONTRIBUTE TO OUR 1954  
CAMPAIGN TO HELP THE MEDICAL SCHOOLS. THIS CAUSE IS WORTHY  
OF THE SUPPORT OF EVERY PHYSICIAN. IF YOU HAVEN'T CONTRIBUTED,  
WON'T YOU CONSIDER DOING SO AT THIS TIME? THANKS.

*Wm. G. H. Dobb*  
Chairman

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Please send a contribution card and information concerning the American Medical Education Foundation.

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## PUBLIC RELATIONS

### COMMITTEE ON PUBLIC RELATIONS

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### Fairfield County Medical Association Announces New Publication

The Fairfield County Medical Association will soon have its own official monthly news publication. In a recently published prospectus outlining the editorial policies of the publication it was announced that it will be titled *News Capsule* and will concentrate on news concerning local medical association activities and the activities of ancillary groups.

Format of the newcomer to the medical news field will be similar to that of a pocket magazine, measuring approximately five and one-half by eight inches, with an attractive two-color cover bearing the association's seal and an appropriate illustration.

Mr. Arnold P. Olson, the association's executive secretary, has been named editor of the publication and it is anticipated the first issue will be out in January. Editorial policy will be directed by a board of eight physicians, comprising Alfred J. Sette, Stamford, chairman; E. Tremain Bradley, South Norwalk; Edwin R. Connors, Bridgeport; M. David Deren, Bridgeport; Frederick W. Finn, Greenwich; D. Olan Meeker, Riverside; and Nicholas P. R. Spinelli, Stratford.

### AMEF Income Passes One Million Mark

The American Medical Education Foundation has received 15,800 physician contributions totalling \$1,023,313 since January 1, 1954.

This represents an increase of more than \$62,000 over the amount subscribed during the same period last year. With only a month to go, both national and state campaign activities have been speeded up to meet a national AMEF goal of \$1,200,000 by the end of the year.

### County Public Relations Manual Announced by AMA

A new public relations manual designed expressly for use by county medical associations has been an-

nounced by the American Medical Association's Public Relations Department.

First editions of the comprehensive new handbook will be available early in December for distribution to county public relations chairmen.

The new manual is the result of years of research into successful public relations programs across the country. These tried and proven programs have been distilled into a step-by-step plan for a successful county program and they are presented in the manual in a format that provides ready references for all types of relationship problems.

Spelled out in the manual is an eight point program comprising emergency call systems; mediation committees; press relations; speakers bureaus; society member indoctrination; provision of medical care for all; public service activities; and citizenship activities. The manual also contains an index and source notes as aids to securing further information.

### Health Education TV Programs Sponsored in Hartford County

A public service health education project is being sponsored by the Hartford County Medical Association in cooperation with WKNB Television, New Britain.

The first phase of the project comprises six five-minute films on first aid and health care, in a series titled "What To Do."

The second phase will present a thirty minute film "A Life to Save," depicting the role of the family physician and the activities of medical associations. The films were prepared by the American Medical Association and are available without charge for use by local medical organizations.

### AMA Health Series in Sunday Newspaper Supplement

The Sunday newspaper supplement, *This Week*, is publishing a series of articles on health topics in

cooperation with the American Medical Association. The first article in the series, published October 16, contained a general statement by Dr. George F. Lull, secretary and general manager of the AMA, expressing appreciation for the magazine's interest in promoting factual health information.

The magazine type supplement has a circulation of nearly 11,000,000 readers. No limit has been set on the number of articles to be published and present plans call for their release to 36 of the nation's leading newspapers. Content of the series will comprise interviews with staff people from AMA headquarters and guest contributors, including a number of physicians. The project is being coordinated through the Bureau of Health Education, AMA.

### Dr. Lynch Retires at Laurel Heights



EDWARD J. LYNCH, M.D.

Dr. Edward J. Lynch retired December 1 as superintendent and medical director of Laurel Heights Sanatorium after 38 years of service.

The institution has evolved under his leadership from a group of small wooden buildings into one of the leading tuberculosis sanatoria in the country. Its facilities are housed in modern fireproof buildings, well equipped for the diagnosis and treatment of tuberculosis and other pulmonary diseases.

Dr. Lynch's supervision has brought wide recognition to the sanatorium for its medical policies. In 1946 Laurel Heights was one of the first sanatoria

to explore the action of specific drugs in the treatment of tuberculous patients and to confirm the value of streptomycin.

Dr. Lynch has held the position of superintendent and medical director of the sanatorium since 1916. He entered the Connecticut Tuberculosis Service in 1912, following intern and residency training at St. Francis Hospital, Jersey City. He is a native of Connecticut and spent his early years in Middletown, where he attended Wesleyan University. In 1908 he received his medical degree at the University of Pennsylvania Medical School.

Dr. Lynch is a member of the Fairfield County Medical Association, the Connecticut State Medical Society and the American Medical Association. He also holds membership in the American Trudeau Society and is a Fellow of the American College of Physicians and the American College of Chest Physicians.

### Red Cross and Civil Defense Sponsor First Aid TV Series

A twenty week television series of first aid demonstrations is being sponsored by the American National Red Cross in cooperation with Connecticut Civil Defense.

Telecast from the studios of WNHC-TV, Channel 8, the series began Tuesday, November 9. The programs are being continued on successive Tuesdays, from 3:00 to 3:30 P. M.

### New Director at Stamford Hospitals

Edgar L. Geibel has succeeded Leroy C. Brown as administrator of Stamford hospitals. Mr. Brown has become administrator of the Phelps Memorial Hospital at Tarrytown, N. Y.

Mr. Geibel comes to Stamford from Rochester, New York where he was assistant director of the Genesee Hospital. He received his education at the University of Detroit, Carnegie Institute of Technology, the University of Pittsburgh and the Yale University School of Medicine. Since 1948 he has been active on the Rochester's hospital council, the regional council, and the Council of Social Agencies. He is a member of the American College of Hospital Administrators and has served on its management methods programs.



## FROM OUR EXCHANGES

"Parkinsonism; Preliminary Report on Two New Antiparkinsonian Agents" is the subject of a discussion by Berris in *Journal Lancet* (74:7). The two agents are MK-02 (tropine benzohydryl ether methane sulfonate) and W-483 (Parsidol or Lysivane).

MK-02 produced subjective improvement in 7 of 20 patients. These patients all received 1 mg. of the drug three times daily or more. In no instance was there objective evidence to show that the symptomatology had improved. Only two patients felt Artane to be less effective than MK-02.

W-483 resulted in objective improvement in 8 of 14 patients. The drug appeared to be nontoxic and seemed to be beneficial to the tremor component of parkinsonism. The dose necessary to produce improvement varied from 30 to 300 mg. a day and all but one of the improved patients received more than 80 mg. a day. In the entire group four patients developed toxic reactions (confusion) which disappeared when the drug was stopped.

\* \* \* \*

Rantz discusses "The Consequences of the Widespread Use of Antibiotics" in *California Medicine* (81:1). Great quantities of antibiotics each year are used with the result that there has appeared a large number of infections caused by organisms that are resistant to the action of one or more of these drugs. The control of resistant infections requires the development of new antimicrobial agents and of new knowledge about the use of older ones in combination.

Dr. Rantz urges the medical profession to be more circumspect in the use of these important drugs or the time may come when the control of many serious infections may become impossible.

\* \* \* \*

"The Psychiatric Aspects of the Menopause" is the subject of an interesting discussion by Wright in *The West Virginia Medical Journal* (L:7). In the opinion of Dr. Wright there is no single psychopathological entity in the menopausal period. The emotional illnesses of this time of life are not directly related to glandular deficiency but rather are the result of the individual's reaction to physiological,

physical and environmental changes taking place in her life. Significant dynamic factors are fear of the menopause itself, reaction to physical aging and loss of physical attractiveness, psychosexual conflicts, the end of the child-bearing period, the feeling of uselessness when the children are grown, and the death of loved ones. A prophylactic approach is indicated, in particular a healthy and scientific attitude of the patient towards the menopause and the development of personality assets and interests for the better use of leisure time.

\* \* \* \*

Segal et al. call attention to the therapeutic value of mechanical respiration in acute and chronic pulmonary disease. ("Intermittent Positive Pressure Breathing," *New Eng. Jour. Med.*, 250:6). Mechanical respiration also has a value in many cardiac conditions. Many types of apparatus have been devised to meet these conditions. Timing, types and site of pressure breathing are factors that enter into all forms of apparatus devised for this purpose. The authors have made a comparison of the various methods employed for pressure breathing.

Intermittent positive pressure in the inspiratory phase of respiration with the simultaneous administration of aerosols of bronchodilators drugs and in many cases pancreatic Dornase has been of value in treating 203 patients with a variety of disorders of the chest.

\* \* \* \*

DeQuervain's Disease is an unfamiliar title to most of us. It was first described in 1895 as a tendon sheath disease, involving two tendons at the base of the thumb. Specifically it consists of a thickened, fibrotic constriction of the common sheath that surrounds the abductor pollicis longus and the extensor pollicis brevis tendons as they course over the groove in the styloid process of the radius. It is not too uncommon a disease if we can judge by the survey of 47 cases made by Wickman and Lamphier (*Jour. Florida Med. Assoc.*, XLI:1). The cause of the disease seems to be trauma. An additional factor may be a tendency to increased tension due to the sudden separation of the tendons upon their exit from the sheath compartment. In any event it seems to

occur most commonly in those occupations that necessitate repeated abduction of the thumb under the stress of grasping positions associated with abduction of the thumb and ulnar deviation of the wrist (such as knitting, golfing, flycasting, piano playing and work on grinding and buffing machines).

The authors pay tribute to the report of a few cases that have recovered under conservative treatment. However, they emphasize that in most cases in which the sheath has become greatly thickened there is no alternative except division and excision of the sheath. All other measures in such a situation have no therapeutic value.

\* \* \* \*

Histoplasmosis, long considered a rare disease, is now found to be a fairly common disease, especially in the middle western United States. Prior et al. report at some length on their experiences with histoplasmosis (*Ann. Int. Med.*, 40:2).

Histoplasmosis is characterized by protean manifestations. Fever, weight loss, cachexia, anorexia, nausea, "indigestion," vomiting, diarrhea, jaundice, cutaneous or mucosal ulceration, cough, sputum, pneumonia that is refractory to all antibiotics, hepatomegaly that is occasionally accompanied by jaundice, splenomegaly and lymphadenopathy, leukopenia and anemia are all mentioned as common symptoms. Diagnostic methods include skin tests, serologic tests and cultures. All are of limited proven value in arriving at a correct diagnosis. Biopsy of lymph nodes, mucocutaneous ulcers and pulmonary and bronchial tissue removed at bronchoscopy may be helpful in arriving at a diagnosis.

There is no satisfactory specific therapeutic agent. The great variation in the clinical course of the disease makes it difficult to evaluate any medication. Ethyl vanillate shows some promise in the treatment of active histoplasmosis. The toxicity and the difficulty of administering this drug has been a deterrent to its use. Atabrine has been found to inhibit the growth of *H. capsulatum* in animals but, if the therapy is delayed until the animal is extremely ill, no benefit from its use has been observed.

All of the sulfonamides and the antibiotics in current use have proved ineffective in the treatment of active histoplasmosis. Streptomycin seems to aggravate the symptoms. The present treatment of histoplasmosis is still largely supportive, in a manner similar to the long established therapy for tuberculosis.

\* \* \* \*

Stein stresses the need for a serodiagnostic test for the general screening of people for cancer. He has made a study of the present status of serological tests for cancer (*Cal. Med.*, 80:1). There have been many serodiagnostic tests for cancer published. None has proved to be a good general test to detect cancer. It is hoped that research in this field will continue. There is at present some hope that such a test will be developed.

\* \* \* \*

"The Solitary Pulmonary Lesion" is reported by May et al. (*Cal. Med.*, 80:1). The authors state that pulmonary cancer when localized in the lung is curable by operation. Lung tumors can often be seen early on x-ray films of the chest.

Out of 40,000 films made routinely as the patient entered the hospital, 60 were found to have an unsuspected solitary lesion of the lung. Since early cancer is surgically curable the authors feel that everyone over the age of 40 should have a routine x-ray examination of the chest every six months. Solitary lesions of the lung should be excised for diagnosis.

\* \* \* \*

Two members of the Department of Medicine, Washington University, St. Louis (Chernoff and Minnich) and one from the Department of Pediatrics, University of Medical Sciences, Bangkok, Thailand (Chongchareonsuk) have discovered, during the course of experiments, a new and abnormal hemoglobin which they have designated as hemoglobin E. This new hemoglobin forms the major component in Mediterranean-hemoglobin E disease and the minor component in the hemoglobin-E trait (*Science*, 120:3120).

\* \* \* \*

Shaughnessy and Zichis (*Bull. World Health Organization*, 10:805) discuss "Treatment of Wounds Inflicted by Rabid Animals." There is a known reluctance on the part of physicians to employ fuming nitric acid as a prophylaxis against rabies. The procedure is painful and destructive of tissue, it slows healing, it promotes bacterial infection, and it is not highly effective.

The authors have attempted, with animal studies, to simulate natural introduction of the virus by inoculation, and to determine effective means of preventing occurrence of the disease.

The experiments were conducted with a fixed rabies virus which was found to be consistent in causing the disease by intramuscular injection. Ex-



tensive ragged wounds were produced in skin and muscle tissue, and the virus was deposited in the wounds and then worked into the muscle tissues to simulate the bite of a rabid animal.

When fuming nitric acid was applied to the wounds, severe chemical burns and scarring occurred in about 90 per cent of the instances, with healing requiring approximately four weeks.

Other treatment methods were employed, and it was found that wounds treated with soap solution, tincture of iodine or Zephiran chloride healed in half the time, without excessive scarring. Zephiran 1 per cent solution was for practical purposes as effective as the 4 per cent solution, without the corrosiveness.

The 1 per cent solution of Zephiran chloride, applied with cotton swabs, was apparently more effective than fuming nitric acid or soap solution, was easier to apply, and did not tend to cause scarring or burns. From these studies, Zephiran chloride 1 per cent solution emerged as the material of choice for the prophylactic treatment of wounds artificially contaminated with the virus of rabies.

It is emphasized by the authors that no treatment prevented all animals from developing the disease, that other approved prophylactics should be employed where indicated.

\* \* \* \*

At the International Congress on Gynecology and Obstetrics held at Geneva, Switzerland in July 1954 Bécclere of France discussed the treatment of uterine myomas with testosterone propionate as the method of choice. After extirpation of myomas in younger women (admittedly a rare occurrence), testosterone should definitely be administered in order to prevent relapses and to combat the functional disorders. In middle-aged women, testosterone should be given in doses of 50-200 mg. per month (individual doses of 25 mg.) until the onset of the natural menopause. Crystalline ampoules make for simpler treatment. Testosterone therapy inhibits the growth of the myoma, and the hemorrhages cease without normal ovarian function being disturbed.

### New Officers Announced by Hospital Association

Andre Blumenthal of Norwalk was named president-elect of The Connecticut Hospital Association

at its annual meeting November 10 in New Haven. Mr. Blumenthal, New York businessman and member of the governing board at Norwalk Hospital, will begin his term of office as President in November, 1955. Albert W. Snoke, M.D., director of Grace-New Haven Community Hospital, elected to the presidency one year ago, was installed as chief executive for the current year. Charles T. Treadway, Jr., of the Bristol Bank and Trust Company, will assume the office of treasurer.

Three persons were also elected as trustees-at-large. These were Clayton C. Chase, New Britain National Bank; Rev. Lawrence E. Skelly, St. Anthony's Church, Litchfield and T. Stewart Hamilton, M.D., director of Hartford Hospital.

Among the regional trustees designated by member hospitals, were William J. Donnelly, administrator, Greenwich Hospital; Frank T. Healey, trustee, St. Mary's Hospital, Waterbury; Joseph P. Cooney, trustee, St. Francis Hospital, Hartford; Albert E. Dolloff, PH.D., director, Charlotte Hungerford Hospital, Torrington; Robert P. Lawton, administrator, Danbury Hospital; and W. Anthony Towle, Jr., superintendent, Bristol Hospital.

The Connecticut Hospital Association includes in its members the 34 short term general hospitals in the State, as well as nine other institutions specializing in specific categories of patient care. The association, organized to assist members in the provision of the best possible patient care, has pioneered in encouraging sound administrative and financial management among its member hospitals. It also maintains a continuing educational program of in-service training for such key hospital personnel as nurses, accountants, purchasing agents, pharmacists, dietitians, medical record librarians, housekeepers and laundry managers.

Its headquarters are located in the building owned by the Connecticut State Medical Society in New Haven.

### Former Connecticut M.D. Heads Medical Writers Group

Lee D. Van Antwerp, formerly on the staff at Undercliff and a former member of the CONNECTICUT STATE MEDICAL JOURNAL Editorial Board, is the new president of the American Medical Writers' Association. Dr. Van Antwerp is associated with G. D. Searle & Company in Chicago.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. Newell W. Giles, Darien*

*President-Elect, Mrs. Norman J. Barker, Collinsville*

*First Vice-President, Mrs. J. ALFRED WILSON, Meriden*

*Second Vice-President, Mrs. Frank L. Polito, Torrington*

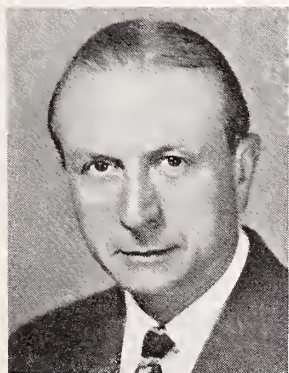
*Recording Secretary, Mrs. Charles Culotta, Hamden*

*Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob*

*Treasurer, Mrs. Joseph Woodward, New London*

A swiftly paced business session prefaced the luncheon at Waverly Inn on November 9 when the State Auxiliary convened for its semi-annual meeting. Mrs. F. Erwin Tracy presented an interim four month budget which will take the Auxiliary from January 1 to April 30, 1955. Thereafter, the fiscal year will run from April 30 to April 30 to coincide with National's fiscal year.

A nominating committee was elected with representation from each county as stipulated in the revised by-laws. The members are: Mrs. Robert Nespor, Fairfield; Mrs. Dewey Katz, Hartford; Mrs. Andrew Orlowski, Litchfield; Mrs. Mark Thumim, Middlesex; Mrs. Joseph Bruno, New Haven; Mrs. Aloys Ansprenger, New London, Mrs. E. J. Ottenheimer, Windham.



DR. H. M. MARVIN

the patient is obese or has either over exerted himself or neglected entirely to exercise.

High blood pressure is the most common and the most serious ailment that the cardiologist sees. It leads to disturbances in the heart, kidneys and brain. However, this is not the fearful malady it was as little as four or five years ago. Then no hope was held out to the patient, but recently numerous and constant advances have been made in its treatment.

Dr. Marvin stressed the virulent effects of tobacco in heart disease. Buerger's disease is found only in persons who smoke. As for exercise, it can and should be done, but mildly, for good health. How-

ever, a person of 50 does not possess the same physical fitness he had at 20 and should taper his physical activities accordingly. Worst of all are the week-end athletics. Aging, pathologically, begins at the age of 19, Dr. Marvin pointed out.

Mrs. Giles introduced four Auxiliary members who have recently received honors. Mrs. Dewey Katz has been named co-chairman of *Today's Health* for the Eastern Region of the Woman's Auxiliary to the AMA; Mrs. F. Erwin Tracy has been named co-chairman of Membership for the Eastern Region; Mrs. Gardner Russell, who for many years has been chairman of the board of directors at Norwich State Hospital, has had one of the hospital buildings named after her; Mrs. Paul Vestal was elected a Representative to the State Assembly.

Dr. Orvan Hess, a member of the Advisory Council, was present at the luncheon. Guests from neighboring States who attended the meeting were: Mrs. Robert Flanders and Mrs. William Latchaw of New Hampshire, Mrs. D. Feinberg of Rhode Island and Mrs. A. J. A. Campbell of Massachusetts.

### Civilian Defense

The new TV First Aid series shown from 3:00-3:30 P. M. over Station WNHC-TV New Haven, was inaugurated November 9 and will run for 20 weeks with a break at Christmas time. Anyone who wishes to receive a TV Civilian Defense certificate in First Aid by watching this program should write the station for a blank and take an examination at the end of the series. The Red Cross First Aid book, an essential, is available at the Red Cross and many book stores.

### Today's Health

Hospital Auxiliaries are cooperating with *Today's Health* Committees in selling copies of *Today's Health* from their magazine wagons and subscriptions through the Hospital Gift Shop.



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tired nerves and mentally depresses patients.

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a shop for contemporary furniture

Christmas Operation is in full swing. The object is "a Christmas Gift Subscription to at least one lay person from every member, or equal to the membership of each local Auxiliary."

Membership

State chairman, Mrs. J. Alfred Wilson, says of the membership situation, "things seem to be looking up!" In 1953-54, Connecticut had a membership of 1,170. National's goal is a 10 per cent increase this year which means we are urged to add 117 members to our Auxiliary. Since April 49 new members have been added. "It is possible and probable," says Mrs. Wilson, there may be some discrepancies in the figures as stated; that dues are paid and new members added at different times in many counties and notification may not have reached the State chairman by this date. It does seem, however, that we are getting off to a fine start for 1954-55. Keep up the good work!"

The breakdown by counties, as of April, is as follows:

COUNTY	NEW	RESIGNED	TOTAL
Fairfield .....	1	5	262
Hartford .....	42	13	424
Litchfield .....	—	—	63
Middlesex .....	3	1	61
New Haven .....	3	—	288
New London .....	—	—	108
Windham .....	—	—	39
Tolland member-at-large .....	—	—	1
Total .....	49	19	1,246

County News

FAIRFIELD

It has been voted to give \$100 to the American Medical Education Foundation. Thirty-eight Christmas gifts have been contributed to Laurel Heights Sanatorium. These, augmented by gifts from the Bridgeport Garden Club, will assure at least one gift for each patient. We hope to raise money for a television set for the hospital by Christmas.

LITCHFIELD

As a public relations project, the Auxiliary has arranged for a series of transcribed radio programs entitled "The Best Is Yet to Be," over the county station WLCR. The fifteen minute programs will run for 13 consecutive Sundays starting January 2; the time is 1:30 to 1:45 P. M.

NEW HAVEN

The Nurse Recruitment Committee is planning to conduct a survey of the hospitals in the county as to the scholarships offered. It will hold a tea for prospective students.

Mrs. William Richards, School Health chairman, conducted a round table discussion in November at the Newhall School in Hamden.

The New Haven County Auxiliary is proud to number among its members a new Representative to the Connecticut State Legislature: Mrs. Paul Vestal of Woodbridge.

HARTFORD

Dr. Dorothy Haustmann, associate professor of preventive medicine, Yale School of Medicine, was guest speaker at the semi-annual meeting held at the Hotel Statler in October. Her subject was "Progress in the Polio Field."

The meeting held on November 15 dealt with legislation. Judge Louis Shapiro of the Superior Court, State of Connecticut, spoke on "How a Judge Views Malpractice Suits." Judge Shapiro, who was formerly a member of the State Legislature, also discussed the passage of a bill through the Assembly. Mrs. Irving Krall was chairman of the meeting.

Mrs. W. H. Lowell, Jr., public relations chairman, and her committee, have distributed Drugpacs to 160 drug stores in the Greater Hartford area for the Diabetes Drive. They also assisted with stuffing the envelopes.

The Medical and Surgical Relief Committee, with Mrs. H. Burness as chairman, has begun its collections.

MIDDLESEX

Mrs. F. Erwin Tracy and Mrs. Henry Sherwood assisted in the Diabetes Detection and Educational Drive which was run in November by the Connecticut Diabetes Association.

For a number of years the Auxiliary has assisted a Christmas Gift Project for Connecticut State Hospital. This year the project will be carried on under the auspices of Dr. John J. Blasko, Commissioner of Mental Health. Mrs. C. B. Crampton is representing Middlesex County Auxiliary on this project and is assisting in setting up local committees for collecting, packaging and distributing Christmas gifts for mental patients.



## NEW LONDON

At the semi-annual meeting Mrs. Newell Giles and Pauline Gurski, director of nurses at William W. Backus Hospital School of Nursing, were guests. A collection was taken for the American Medical Education Foundation and the fund will receive \$48.50.

A Membership Tea will be held December 7 at the home of Mrs. Sidney Drobnes in Norwich. There will be an art-musical program.

## AMA's Opposition to Administration Proposals

### REINSURANCE

The stated purpose of the reinsurance proposal is to "encourage and stimulate private initiative in making good and comprehensive health services generally accessible on reasonable terms." While in complete agreement with that objective, the AMA opposed the reinsurance bills for these reasons.

1. The mechanism suggested would not accomplish the stated purposes of the bills.

2. The phenomenal progress of the health insurance industry makes federal intervention not only unnecessary but a dangerous intrusion into a successful area of private enterprise.

3. "Reinsurance" would not make health insurance more attractive to persons who can afford to pay premiums and have not done so. It would not make health insurance available to the indigent unless the government provides a subsidy for the purpose of selling insurance at less than the cost of servicing the contract.

4. The program, without subsidy, would not make health insurance available to any additional groups or geographic areas that voluntary insurers cannot reach.

5. Most insurance authorities agree that the extent of health insurance liability is such that a federal reinsurance program is absolutely unnecessary.

6. The bills would give the Secretary of the Department of Health, Education and Welfare an extensive but unjustified regulatory control over the nation's health insurance industry.

### SOCIAL SECURITY AMENDMENTS

The AMA took a position on only two provisions in the bill to amend the Social Security Act—(1)

the proposed compulsory coverage of physicians under Title II of the Act and (2) the so-called "waiver of premium" section to preserve the insurance rights of individuals with extended total disability. The Association opposed those two provisions, which were of direct medical interest, but took no position on the bill as a whole, which would be outside its province.

**Compulsory Coverage**—The AMA House of Delegates on at least three occasions in the recent past has expressed strong opposition to compulsory coverage, but it has made clear that it does not oppose voluntary coverage for any physicians who might desire it. We oppose compulsory coverage because: (a) most physicians do not retire until after the age of 74 and therefore would not benefit; (b) group treatment does not apply logically to physicians, whose lives and training emphasize individual activity, and (c) there is no sound reason for compulsory coverage of a group against their expressed wishes.

**The Jenkins-Keogh Bills**—As an alternative to compulsory coverage under Social Security, the AMA actively supports the Jenkins-Keogh bills, which would provide tax deferment benefits designed to stimulate the establishment of retirement pension plans by self-employed persons and by many employed persons not now covered by company plans. In the opinion of the AMA these bills will provide for the development of a voluntary pension program which is equitable, free from compulsion and attuned to the retirement needs of physicians. Moreover, these bills will eliminate certain discriminations and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self employed and also to millions of employees who work for companies without private pension plans.

**Waiver of Premium**—This section of the Social Security amendments provides a waiver of Social Security taxes for those totally and permanently disabled, with the disability to be determined by medical examinations carried out under government regulations. The AMA opposed this section because it could become an entering wedge for the regimentation of the medical profession by creating a mechanism for the adoption of a federal cash permanent and total disability benefit program which in turn could lead to a full-fledged system of compulsory sickness insurance. This section, therefore, cannot be appraised solely as an isolated, detached effort to provide some measure of aid to disabled workers.

## SPECIAL NOTICES

### THE REHABILITATION STUDY UNIT 1954-1955

Fitkin Amphitheater, Alternate Tuesdays, 4:00 P. M.

October 26

Introduction to Rehabilitation

Dr. Joseph Benton, New York University-Bellevue Medical Center

November 9

Cerebro-Vascular Accidents

Dr. Gilbert Glaser

Dr. Joseph Sokal

November 23

Cerebro-Vascular Accidents—Rehabilitation

Dr. Thomas Hines

December 7

Arthritis

Dr. Gideon de Forest

Dr. Frieda Gray

January 18

Arthritis—Rehabilitation

Dr. Ed Lowman, New York University-Bellevue Medical Center

February 1

Poliomyelitis

Dr. Robert Bennett, Warm Springs

February 15

Poliomyelitis

Dr. Ned Shutkin

Dr. Thomas Hines

March 1

Rehabilitation of Hearing Problems

Dr. John Kirchner

March 15

Cerebral Palsy

Dr. M. A. Perlstein, Chicago

March 29

Spinal Cord Problems

Dr. William German

Dr. Thomas Hines

April 12

Spinal Cord Problems

Dr. Marvin Harvard

Psychiatrist, Bellevue

April 26

Emotional Problems of the Physically Handicapped

Dr. Lidz

May 10

Chronic Neurologic Diseases—Multiple Sclerosis, Muscular Dystrophy, etc.

Dr. Gilbert Glaser

Dr. Thomas Hines

May 24

Braces and Prostheses

Dr. Thomas Hines

Dr. Charles Bechtol

June 7

Rehabilitation of Speech Disorders including Cleft Palate

Dr. John Kirchner

June 21

Demonstration—Rehabilitation Panel

Grace--New Haven Hospital

### E.N.T. SCHEDULE, DECEMBER 1954

#### Yale University School of Medicine

December 1 5:00 P. M.

Film

4:00 P. M.

Chest conference

December 6 5:00 P. M.

Head and neck anatomy demonstration

December 8 4:00 P. M.

Case presentation nasal surgery

December 10 4:00 P. M.

Chest conference

December 13 5:00 P. M.

Head and neck anatomy demonstration

December 15 5:00 P. M.

E.N.T.—Radiology conference

December 17 4:00 P. M.

Chest conference

December 20 5:00 P. M.

Head and neck anatomy conference

December 22 5:00 P. M.

E.N.T.—Surgical pathology conference

E.N.T.—Surgical pathology conferences held in large autopsy room, Brady Building.

E.N.T.—Radiology conferences held in Radiology classroom, 2nd floor, Clinic Building.

Chest conferences—Fitkin Amphitheatre.

Wednesday afternoon meetings in E.N.T. clinic waiting room, 4th floor, Clinic Building.

Anatomy demonstrations—Prosector Room, 3rd floor, Sterling Hall of Medicine.



## CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

December 2

The Role of the Physician in Civil Defense

Film: Operation Ivy

William E. Lake, area director of Civil Defense

December 9

Diseases of the Chest—Report on ACCP Course

Einar A. Lundberg, M.D.

December 16

Clinicopathological Conference

Paul M. Sherwood, M.D., moderator

December 23

Case Presentation: Cushing's Syndrome

James S. Missett, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room. All interested physicians are cordially invited to attend.

## LECTURES ON INDUSTRIAL HEALTH

The Committee on Industrial Health of the Connecticut State Medical Society in conjunction with the Yale University School of Medicine will sponsor a winter series of eight lectures for the Bridgeport Chapter of the American Academy of General Practice dealing with medical problems in industry of interest to every practicing physician in this area. At the first meeting on November 12 at Bridgeport Hospital Preston Barton, medical director of the New Departure Division of General Motors Corporation, discussed "Back Injuries," and on December 3 John Gallivan, medical director at United Aircraft will speak on "Workmen's Compensation." Subsequent speakers will deal with a wide range of subjects which include Industrial Dermatoses, Cardiacs in Industry, Medical Testimony, etc., and the general plan will call for about 50 minutes of prepared material followed by a discussion period. This series should be of real practical value to every general practitioner as well as to those men who limit their work to special fields.

The schedule of lectures on eight Friday evenings at the Bridgeport Hospital at 8:30 P. M. follows: 1954—November 12, December 3; 1955—January 7 and 28, February 11 and 25, March 11 and 25.

This is an accredited course by the AAGP for postgraduate study requirements and an administrative fee of ten dollars for the series will be made. Interns and residents from any hospital will be welcomed for any or all of the lectures without charge, and this course is open to all interested physicians whether they are members of the AAGP or not. For registration and additional information please contact the secretary.

Dr. Edwin F. Trautman, 5367 Main Street, Trumbull 702, Connecticut. AMHerst 8-1478.

## N. Y. ACADEMY OF MEDICINE

The pathology and treatment of optic nerve diseases will be discussed by Dr. Joseph Igersheimer, Boston, at the eighth annual Mark J. Schoenberg Memorial Lecture, to be held at the New York Academy of Medicine on Monday, December 6, at 8:00 P. M.

The National Society for the Prevention of Blindness and the New York Society for Clinical Ophthalmology sponsor the lecture in memory of Dr. Mark J. Schoenberg, who died in 1945.

## ANNUAL CONGRESS ON OBSTETRICS AND GYNECOLOGY, DECEMBER 13-17

Every phase of maternal and newborn care will be covered at the Sixth American Congress on Obstetrics and Gynecology, to be held in the Palmer House, Chicago, December 13-17.

The five day meeting, which is expected to draw an attendance of about 3,500, will be under the sponsorship of The American Committee on Maternal Welfare, Inc., and The American Academy of Obstetrics and Gynecology.

The program, designed for physicians, nurses, public health officials and hospital administrators concerned with mother and baby care, will include approximately 30 formal papers, 22 symposia and panels, luncheon discussion groups and round-table discussions. Scientific and technical exhibits will present the latest developments in the field.

## MYASTHENIA GRAVIS CONFERENCE

Conference on Myasthenia Gravis, auspices of the Myasthenia Gravis Foundation, Inc., December 8 and 9, 1954, School of Medicine—University of Pennsylvania, Philadelphia, Pa.

Physicians and students welcome.

Address all communications to: The Myasthenia Gravis Foundation, Inc., 2 East 103rd Street, New York 29, N. Y.

## STATE AMEF CHAIRMEN TO MEET

American Medical Education Foundation state chairmen will kick off the 1955 fund-raising campaign with a meeting Sunday, January 23, at the Sheraton Hotel, Chicago. This fourth annual meeting will launch officially the medical profession's concerted efforts to raise voluntary funds for the nation's medical schools. Primary purpose of the one-day session is to exchange ideas on local promotions. Representatives from every State, as well as regional auxiliary chairmen, will be on hand for the meeting.

## AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Office of the secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

The next scheduled examination (Part 1), written examination and review of case histories, for all candidates will

be held in various cities of the United States, Canada, and Military centers outside the continental United States, on Friday, February 4, 1955.

Case abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

### REGULAR CORPS EXAMINATIONS FOR MEDICAL OFFICERS, USPHS

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held in various places throughout the country on February 15, 16, and 17, 1955.

Appointments provide opportunities for career service in clinical medicine, research, and public health. They will be made in the ranks of Assistant and Senior Assistant, equivalent to Navy ranks of Lieutenant (j.g) and Lieutenant, respectively.

Entrance pay for an Assistant Surgeon with dependents is \$6,017 per annum; for Senior Assistant Surgeon with dependents, \$6,918. Provisions are made for promotions at regular intervals.

Benefits include periodic pay increases, 30 days annual leave, sick leave, medical care, disability retirement pay, retirement pay which is three-fourths of annual basic pay at time of retirement, and other privileges.

Active duty as a Public Health Service officer fulfills the obligation of Selective Service.

Requirements for both ranks are U.S. citizenship, age of at least 21 years, and graduation from a recognized school of medicine. For the rank of Assistant Surgeon, at least 7 years of collegiate and professional training and appropriate experience are needed, and, for Senior Assistant Surgeon, at least 10 years of collegiate and professional training and appropriate experience are needed.

Entrance examinations will include an oral interview, physical examination, and comprehensive objective examinations in the professional field.

Application forms may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C. Completed application forms must be received in the Division of Personnel no later than January 12, 1955.

### EXPERIMENTAL RESEARCH INTO PROBLEMS OF AGEING

The Trustees of the Ciba Foundation for the Promotion of International Cooperation in Medical and Chemical Research, 41, Portland Place, London, W.1, wishing to encourage well-conceived research relevant to basic problems of ageing, invite candidates to submit work in the field for Awards for 1954-55. Details of the conditions may be obtained on application to the undersigned, but in general candidates should note:

(a) Five awards, of an average value of £300 each, are available for the period 1954-1955. The announcement of awards will be made in July 1955.

(b) Entries must be received by the undersigned not later than February 28, 1955.

(c) Entries will be judged by an independent international panel of distinguished scientists who will advise the Executive Council of the Foundation on their findings and will also have power to recommend variation in the size and number of the awards according to the standard of entries. The decisions of the Executive Council will be final.

(d) In making the awards preference will be given to younger workers.

(e) The work submitted should be unpublished (but may be under consideration for publication) at the closing date for entries.

(f) The papers may be in the candidate's own language, but a summary in English not exceeding 500 words must be attached.

(g) Where there are one or more co-authors, the name of the leading author should be indicated; it is to him that the award will normally be made, and it will be left to his discretion to share this award appropriately with his co-authors.

G. E. W. Wolstenholme, director and secretary to the Executive Council.

### NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The eighteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7-10, 1955, headquarters at the Municipal Auditorium.

### LATIN-AMERICAN NEUROSURGICAL CONGRESS

The Sixth Latin-American Neurosurgical Congress will be held in Montevideo, March 21 to 24, 1955, under the auspices of the Government of the Republic of Uruguay. The Congress will feature a symposium on the thalamus; speakers will include Dr. R. Hassler, Dr. H. Fernández Morán, Dr. H. Jasper, Dr. H. W. Magoun, Dr. L. van Boggert, Dr. J. Talairach, Dr. E. Walker and Dr. P. Bailey. Other official reports will deal with cisternal herniations, pain surgery and dyskinesias.

### N. Y. ACADEMY OF MEDICINE HEALTH EDUCATION CONFERENCE

1955 Eastern States Health Education Conference of the New York Academy of Medicine will be held on Thursday and Friday, April 21 and 22, 1955.

### ATLANTIC CITY MEETING, AMERICAN MEDICAL ASSOCIATION, JUNE 6-10, 1955

The Council on Scientific Assembly announces the deadline for those who wish to participate in the Atlantic City Meeting, either by reading a paper or presenting a scientific exhibit.

Deadline for section papers, December 15, 1954.



Deadline for scientific exhibit, January 10, 1955.

Applicants should communicate with the Secretary or the Representative to the Scientific Exhibit of the Section in which they are interested. Further information may be obtained from the secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

### FELLOWSHIPS IN INDUSTRIAL MEDICINE

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of Industrial Medicine. Any registered physician who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Experience in private practice or service in the Armed Forces may be substituted for one year of training.)

The course of instruction consists of a two year period of intensive training in Industrial Medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Science in Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from \$3,000 to \$3,600 in the first year and \$3,400 to \$4,000 in the second year. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

A one year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

### AMA OFFERS STANDARD NOMENCLATURE INSTITUTE

A new short course offering expert instruction and helpful suggestions on the correct way of utilizing "Standard Nomenclature of Diseases and Operations" in the hospital, doctor's office, or clinic will be offered February 7-8-9 at AMA headquarters, Chicago.

Sponsored for the first time by the American Medical Association, the three day Standard Nomenclature Institute program will be divided into three parts: (1) Lectures covering basic principles, construction, and installation, plus discussion on the tumor and operation sections and the handling of specific problems; (2) anatomy as it pertains to the topographic section, and (3) practice in coding to be offered at two evening sessions.

Because of limited facilities, registration will be limited to 150 "students." Application blanks will be distributed after December 1.

Instructors will be Adaline C. Hayden, R.R.L., associate editor of Standard Nomenclature, AMA, and Edward T. Thompson, M.D., chief of programs operation, hospital facilities, USPHS, Washington, D. C.

### EDITORIAL POSITION AVAILABLE

The position of Publications Editor is available with the Historical Unit of the U. S. Army. The work is concerned with the task of compiling the clinical as well as the administrative aspects of World War II. Requirements include extensive medical vocabulary, experience in preparing rough drafts of clinical material for publication, ability to edit rough drafts of submitted material and rewriting. Those interested should address: I. H. Ahlfeld, Major—MSC, executive officer, Historical Unit, Office of the Surgeon General, Department of the Army, Washington 25, D. C.

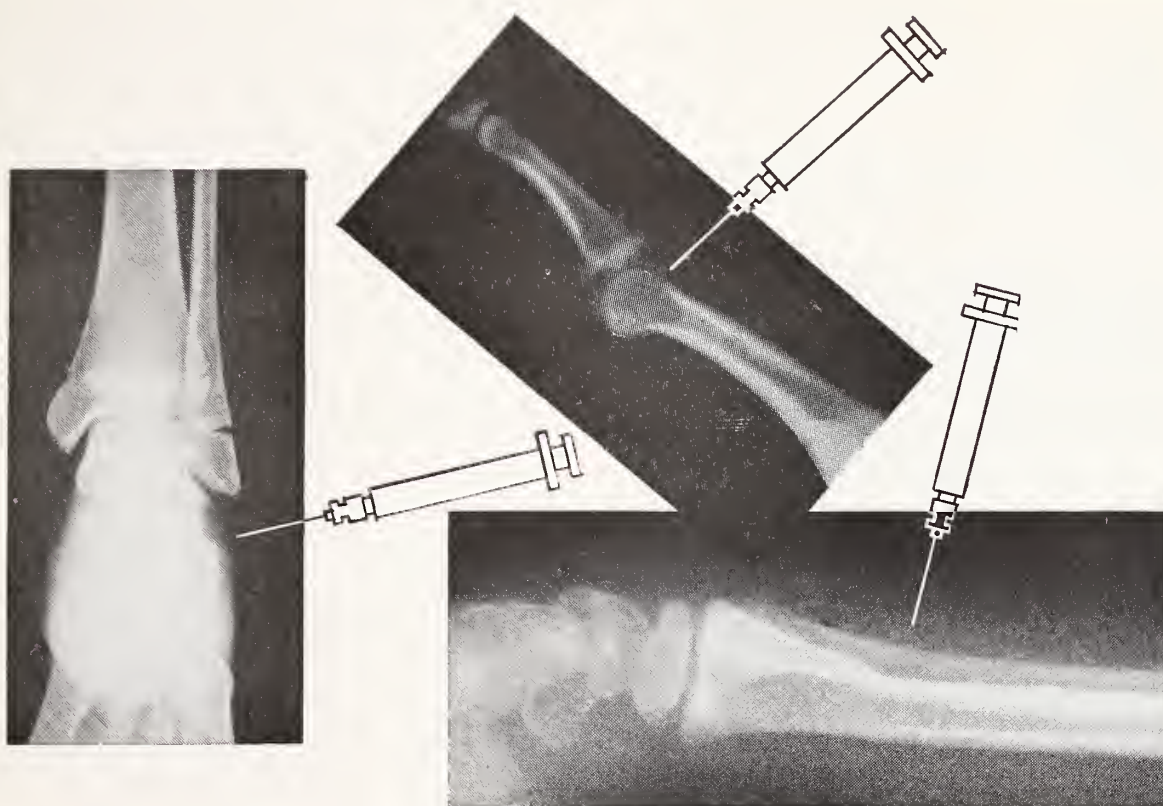
### Navy Crew Honors Shipmate With Memorial Fund

Capt. Charles L. Wertz, USN, commander of a Navy supply transport, recently forwarded a check in the amount of \$147.31, representing a contribution to the American Medical Education Foundation from the crew of the USS Achernar in honor of their shipmate, Hospital Corpsman Third Class John Phillip Blackmer, who was lost at sea.

In his letter to the Foundation, Captain Wertz advised us that during his service aboard the USS Achernar, "John Phillip Blackmer earned the genuine respect and admiration of all his associates for his professional abilities as a hospital corpsman, and their affection for him as an individual. It had been his hope on completion of his current enlistment in the Navy, to finish his college education and to go on to medical school." Captain Wertz added: "His ability and interest in the care of patients indicated that he would have been a credit to the profession, as well as to the Navy and to all who knew him."

### \$5 Million Too Much

A city department head recommended deletion of \$5,000,000 from the 1955 New York City budget for new clinic and ward bed facilities "because voluntary medical and hospital insurance has made such expense unnecessary"? According to CMS this is official significant confirmation that Blue Shield and Blue Cross convert clinic and ward patients to personal physician care.



## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

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Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.



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## New England Council of State Medical Societies Meets in Boston

A conference on postgraduate medical education and the proposed compact to further education in medicine and dentistry in the New England States featured a meeting of the Council of New England State Medical Societies, October 25 in Boston.

Held at the Statler Hotel, the conference was attended by approximately 25 representatives from the Council's component state medical associations.

Dr. Laurence B. Ellis, president of the Board of Director, Postgraduate Medical Institute, was principal speaker at the afternoon session of the conference.

Speakers for the evening session were Senator George J. Evans, Boston, chairman of the Governor's Committee for the New England Compact, and Dr. James M. Faulkner, dean of the Boston University School of Medicine.

Dr. Eugene H. Drake, of Portland, Maine, president of the Council, presided at a brief business session.

It was voted to refer a Connecticut proposal for a regional conference on rural health to component associations. It was also voted that the Council offer its assistance to the Arrangements Committee of the Massachusetts State Medical Society in connection with the AMA Clinical Session to be held in Boston in December, 1955.

## 1955 Connecticut Spring Flower and Garden Show

The ninth annual Connecticut Spring Flower and Garden Show will be held March 10-16, 1955 in West Hartford State Armory, 836 Farmington Avenue, Mr. David R. Daniel, publisher of *The Times* announced on November 4.

Receiving added popularity among flower and garden lovers as well as new home owners, each year, the show will be staged by *The Times* in cooperation with the Connecticut Nurserymen's Association, The Hartford Branch of The National Association of Gardeners, Connecticut Horticultural Society, Allied Florists of Greater Hartford and the Federated Garden Clubs of Connecticut. Members of these organizations throughout the State will take an active part in preparing the show.

"Through the Garden Gate—in Springtime" will keynote the show, now being designed by Mr. George H. Hollister, working with the general

committee. Mr. Hollister has long years of experience as park director of the City of Hartford, from which he has recently retired. His successful and extended work with the rose gardens of Elizabeth Park is known internationally.

Experts in gardening, lawn making, turf building and flower arrangers will produce a spectacular show which appeals more and more each year, not to Connecticut residents alone, but visitors from the metropolitan areas of New York and Boston.

### The Institute of Living Goes Deeper in the Red

Again the annual report of the Institute of Living in Hartford is thought provoking, especially that part of it written by the physician in chief, Francis J. Braceland. Last year in an editorial the JOURNAL pointed out the inconsistency of a nonprofit institution suffering from a heavy deficit while being forced to pay a city tax of \$103,000. This year the Institute sustained a net loss of \$112,786.17 compared to \$9,577.76 for the previous year. As the president of the Institute points out, "the result of such a policy (of a tax levy upon a private nonprofit hospital) must be the inevitable extinction of private hospitals and the socialization of all hospital care."

Whether or not this was the intent of the State Legislature in withholding from the Institute the tax exemption privilege, it is operating to the detriment of society and the practice of medicine.

### Educational Health Articles Lead in National Magazines

A rising tide of educational articles concerning health and medical care reached a new crest in November. During that month 14 leading national magazines with a combined circulation of more than 50,000,000 published 19 articles on subjects ranging from "How to Choose a Family Doctor" to childbirth, headaches, heart attacks, use of modern drugs, weight loss, surgery, conception and the disease free areas of South America.

December magazines also will reach subscribers and news stands with a plentitude of health education material. *Look's* December 14 issue will publish a piece on the treatment of heart attack. *Changing Times*, the Kiplinger magazine, has scheduled a special article on budgeting for medical and hospital care through voluntary health insurance. Other December subjects will comprise the story of the nursing team, *Redbook*, and fertility, *Cosmopolitan*.

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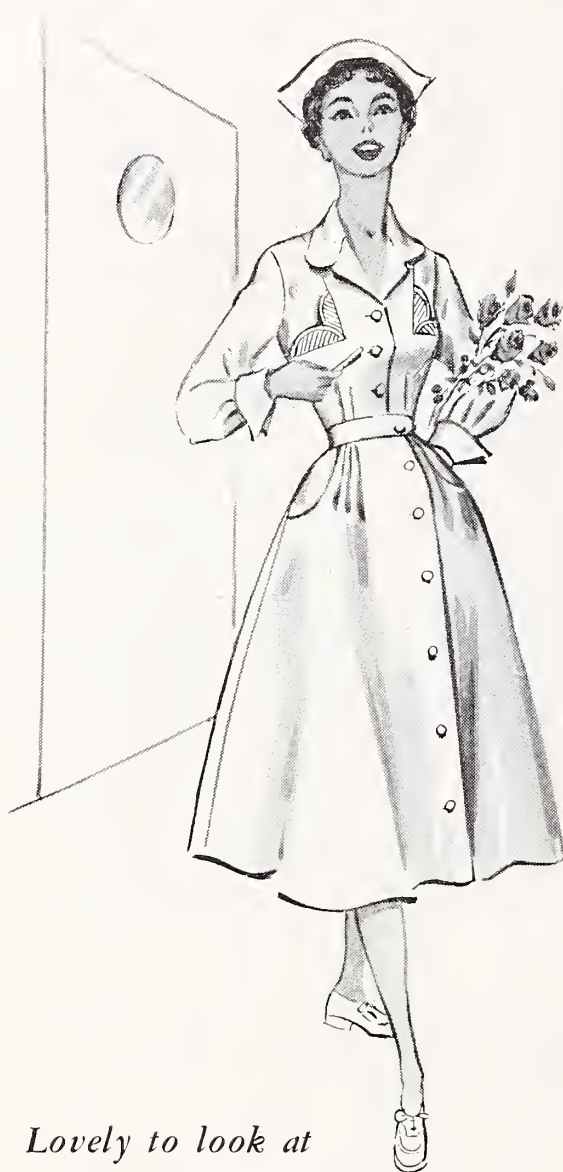
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A *Collier's* article on heart drugs and another on operative procedures for schizophrenia are scheduled for early issues.

The following schedule indicates the magazines in which the November articles appeared, their circulation, and titles and summaries of the articles:

*Woman's Home Companion*, November, 1954 (Cir.: 4,442,000) "New Wonders of Conception," by Dr. Herbert Thoms with Bruce Bliven, Jr. (Note: Special comment on the above article will be published in a subsequent issue.)

*American Legion Magazine*, November, 1954 (Cir.: 2,800,000) "How to Pick a Doctor," by Tom Mahoney. Subtitle: "You may live longer and feel better if you find the right physician."

Summary: A thorough discussion of why it is important to pick a doctor before you are sick, plus an outline of steps to take in order to find the physician best suited to your needs.

*American Magazine*, November, 1954 (Cir.: 2,600,000) "How to Choose a Family Doctor," by Alice Lake. Subtitle: "Finding just the right physician for you and your children will pay off in large dividends of health and happiness. These experiences of a widely known writer on medical subjects will help you make a selection."

Summary: This treats the subject from a first person point of view. Mrs. Lake reports on experiences of her family and of friends, concluding with five "tips on selecting a physician."

*Life*, November 1, 1954. "A Baby's Heart is Mended." (picture story). Subtitle: "Operation joins mother's bloodstream to child."

Summary: Pictures and diagram show how University of Minnesota doctors operate on a five-month-old baby girl while blood from her mother's body is circulated through the child.

*Redbook*, November, 1954 (Cir. 2,000,000) "It's Great to Have a Baby in Flint, Michigan," by Jean Liebman Block. Subtitle: "A city famous for turning out sleek automobiles has discovered the secret of producing healthier babies, happier mothers—and more helpful fathers."

Summary: Reports on activities of the Clara Elizabeth Fund for Maternal Health which offers "young adults a helping hand at every important turn of their lives as they pass from courtship to marriage, to pregnancy, to childbirth, to adjustment to the new baby, and on to more babies."

*Reader's Digest*, November, 1954 (Cir.: 5,155,000) "Islands of Immunity—Medicine's Most Amazing Mystery," by Eugene H. Payne, M.D. Subtitle: "Deep in South America a well known physician found nine areas, each magically free of a major disease."

Summary: Digested from August 8, 1954 issue of *This Week*, the article tells about villages in Brazil each immune "to a particular disease that challenges modern medicine: heart disease, cancer, malaria, hookworm, tooth decay, mental illness."

Same issue: "Let's Stop Abusing Hospital Insurance," by Blake Clark. Subtitle: "Free-loaders are driving up the cost of insurance. Here's how they do it—and how they can be stopped."

Summary: Points up abuses of health insurance resulting from patients going into hospitals for diagnosis or for treatment of conditions that could be treated at home. Based primarily on study by Michigan State Medical Association.

Same issue: "An Unforgettable Character," by Robb White. Subtitle: "One of the South's greatest physicians, Dr. 'Tom' McIntosh of Thomasville, Ga., also led a secret life."

Summary: A human interest story of a highly skilled, warm-hearted physician who devoted his lifetime to serving his southern Georgia community.

Look, November 2, 1954 (Cir.: 3,399,000) "My Operation Under Hypnosis." Subtitle: "Janice Easton, a British Nurse, says it was like a lovely sleep."

Summary: The nurse describes her feelings while undergoing a "serious breast operation" for an hour and twenty minutes without anesthesia except hypnosis. Despite 100 stitches she felt well and "had no memory of pain or unpleasantness."

Look, November 30, 1954 (On news stands November 16) (Cir.: 3,400,000) "The Man Behind the 'Medic'." Subtitle: "A writer who fascinates audiences with medicine lived in hospitals for three years researching TV series."

Summary: A short picture feature showing how Jim Moser, writer of "Medic," boned up on medical subjects so that the television series would be accurate.

Saturday Evening Post, November 6, 1954 (Cir.: 4,500,000) "Doctor Kalmann's 7,000 Twins," by Morton M. Hunt.

Summary: "Every year Dr. Franz Josef Kallmann spends many months looking for twins—preferably identical, preferably insane. Why? To help solve the ancient riddle Is mental illness a matter of heredity? Here are some of the startling results of his adventures."

Same issue: "The Doctor Was a Fake."

Summary: No medical school training, no license—yet Harold Rain practiced as a surgeon and a specialist in obstetrics and gynecology for seven years in eight states. The story of an astounding deceiver.

Good Housekeeping, November, 1954 (Cir.: 3,410,000) "The Handling of a Heart Attack," by Maxine Davis. Subtitle: "How to recognize an attack and basic rules for what to do."

Summary: Some misconceptions about heart attacks and common causes of heart disease are explained. The author tells how to live with heart trouble and what to do in case of sudden attack, stressing reliance on the physician.

Collier's, November 12, 1954 (Cir.: 3,200,000) "Should Blood Banks Make Money?," by Bill Davidson. Subtitle: "The Red Cross and doctors say no. But often patients pay high prices."

Summary: A Collier's editor reports varied blood bank methods that have sprung up since the end of World War II, pointing out abuses and attempts being made to straighten out the situation.

Pageant, November, 1954. "The World's Simplest Diet," by Peter Stevens. Subtitle: "Remember one simple sentence and lose 20 pounds in 30 days."

Summary: A mnemonic for remembering 22 "mustn't touch" foods is given. The author says other rules about calories, etc., can be ignored if these 22 foods are strictly avoided.

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Same issue: "The Second Birth of Loren Peck," by Cal Bernstein.

Summary: A photographic report with text explaining how 20 year old Loren was "rebuilt" after an auto accident which left him partly crippled and completely without memory following a 6 month coma.

*Coronet*, November, 1954 (Cir.: 2,795,000) "Penicillin Turns Killer!," by Lawrence Galton.

Summary: Death and ill effects from penicillin are reported and causes explained. Steps to prevent them are outlined and the author suggests that the lesson of penicillin be applied to other antibiotics as well.

## OUR NEIGHBORS

### Vermont

Howard J. Farmer of St. Johnsbury was installed as president of the Vermont State Medical Society at its annual meeting in October. The delegate to the Connecticut State Medical Society is Francis Herrick. Dues remain at \$35.

## NEWS

### *from County Associations*

### Fairfield

William Kaufman of Bridgeport, president of the Academy of Psychosomatic Medicine, will address the Springfield Branch, American Association for the Advancement of Science on "The Dangers of Psychosomatic Diagnosis Treatment" at the Springfield Academy of Medicine on February 8, 1955.

Charles Winfield Perkins of Norwalk died in Baker Memorial Hospital, Boston on October 7. Dr. Perkins was a radiologist on the Norwalk Hospital staff and former chairman of the Norwalk Cancer Society.

The Bridgeport Medical Association held their regular monthly meeting at the auditorium in Bridgeport Hospital on the evening of November 2. Dr. Benjamin I. Ashe, associate clinical professor of medicine at Post Graduate Hospital, New York, spoke on the "Everyday Management of Diabetes Mellitus."

Michael Dean, Joseph DeLuca and Joseph Adzima were appointed as a nominating committee by the

Bridgeport Medical Association to select a slate of officers for the year 1955 to be presented at the December meeting of the association.

### Hartford

William Beecher Scoville of Hartford discussed "Partial Section of Proximal Extracranial Portion of Seventh Nerve for Facial Spasm" (see *CONNECTICUT STATE MEDICAL JOURNAL*, XVIII, 11, November 1954) at the Forum on Fundamental Surgical Problems during the Clinical Congress of the American College of Surgeons held in Atlantic City, November 15-19.

The Hartford County chapter of The American Academy of General Practice held their annual dinner at the Statler Hotel on November 11. The guest speaker was Rev. Russell Stafford, president of the Hartford Seminary Foundation.

Charles T. Schechtman of New Britain was one of the speakers at the testimonial dinner recently held by the New Britain Dental Society in honor of the dean of the Baltimore College of Dental Surgery, Dr. Myron S. Aisenberg. As first vice president of the State Medical Society Dr. Schechtman acted as the Society's official representative.

Burdette Buck, Clair Rankin, LeRoy Wardner, Samuel Rowley, Egbert M. Andrews and E. Myles Standish, all members of the Hartford Hospital staff, are participating in a lecture course on Tropical Hygiene being given to students of the Kennedy School of Missions of the Hartford Seminary Foundation.

WKNB-TV is programming a series of 6 five-minute films called "What To Do" which deal with household medical problems, and a fifteen minute short film called "A Life To Save." All films have been prepared by the AMA and will be presented by HCMA as a public service feature.

Robert J. Molloy, a new Hartford County Medical Association member, lectured to a group of students at the Hartford High School adult evening program on "miracle drugs." A joint adult evening program, sponsored by Greater Hartford Tuberculosis and Public Health Society and Hartford County Medical Association at Hartford High School, covers a six week lecture period running through October and November. Participating in the adult evening series were: Wilson F. Smith, October 6, who spoke on "You Can Weigh What You Want To;" A. Arthur Fierberg who spoke on

"New Hope For Cancer Control" on October 20; Charles McLean on "Let Your Head Rule Your Heart," October 27; Ludwig Frank on "Emotional Problems," November 3; and James S. Missett who will close the series with "Activities—When to Slow Down."

Hosts for the northeast regional meeting of the American College of Physicians were the Connecticut Fellows and Associates of the American College. John C. Leonard, a governor of the ACP, presented the greetings to the guests at the opening of the first session. Wilson F. Smith was in charge of the scientific program. Assisting him were Samuel Donner, Louis Hastings, William J. Lahey, Edward Nichols, Paul H. Twaddle and Otto G. Wiedman. In charge of entertainment was Walter Weissenborn. On his committee were: Ralph E. Kendall, Benjamin White, George A. Wulp, and Arthur B. Landry.

Isidore Schnap, chief of the VA Hygiene Clinic, opened the seventh annual fall series of lecture and discussion programs on "The Psychology of Human Relations" at the Adult School (Hartford). This program was sponsored by the National Conference of Christians and Jews.

John B. Griggs was one of the participants in the third medical conference of the Muscular Dystrophy Associations of America recently. He was a chairman on a symposium on clinical management of this disease.

Philip J. Moorad delivered a paper entitled "Medical Management of Psychiatric Problems" to the Alumna Association meeting of the University of Rochester Medical School.

Roger T. Scully and Dr. Francis S. Buccheri spoke to the New Britain Cana District for engaged couples recently.

Jacob Mellion, New Britain school doctor, has been elected chairman of a new health, safety and physical education council of the school department.

Timothy Curran has been elected a fellow of the American Laryngological, Rhinological and Otolaryngological Society.

Francis D. T. Bowen has been reelected a governor of the American College of Chest Physicians.

Henry R. O'Brien, a member of the U. S. Public Health Service, Department of Health, Education and Welfare in Washington has written an article on "International Responsibilities and Opportunities in Relation to Foreign Medical Education," published in *The Journal of Medical Education*, March 1954. Dr. O'Brien continues to maintain his membership in the Connecticut State Medical Society.



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Thomas J. O'Connell has joined the staff of the Blue Hills Hospital in Hartford as a specialist in internal medicine. Dr. O'Connell served his internship at St. Francis Hospital, Hartford, followed by two years on active duty with the U. S. Navy at Quonset, R. I.

Sister Bernard Mary, administrator of St. Francis Hospital, Hartford has been appointed to the National Advisory Heart Council.

### Middlesex

James Cary, who had been associated with Alfred Sweet for several years, joined a group practice in Ohio. James R. Glessner, Jr. is the new associate of Dr. Sweet.

The semi-annual meeting of the county society was held at Restland Farms in Northford on October 14. D. Olan Meeker, the chairman of our State Society committee on legislation, was the speaker of the evening. His topic was "Medical Legislation."

Julius Grower was elected president of the Connecticut Academy of General Practice at the recent annual meeting of that organization.

### New Haven

William J. German was co-author with Sidney N. Paly of a paper on "Brain Electrolyte Patterns in Response to Saline and ACTH" presented at the Forum on Fundamental Surgical Problems during the Clinical Congress of the American College of Surgeons held in Atlantic City, November 15-19.

Paul B. Beeson, Ensign professor of medicine and William H. Resnick, associate clinical professor of medicine, Yale University School of Medicine, are listed among the editors of the new second edition of Harrison's Principles of Internal Medicine.

### New London

At last month's regular staff meeting of the William W. Backus Hospital in Norwich, William Lord reported on the activities of the second cardiological congress in Washington. This month's program consisted of case presentations by members of the various services.

At the monthly dinner lecture of the Lawrence and Memorial Hospital on October 21 Samuel Proger, professor of medicine, Tufts College Medical School, spoke on "Recent Advances in Coronary Disease."

The New London Chapter of the Connecticut Heart Association held its monthly lecture on October 28 at the Lawrence and Memorial Hospital. Arthur Girshman, assistant attending physician at Mt. Sinai Hospital, New York and instructor in medicine at Columbia, spoke on vector cardiography.

The monthly meeting of the New London County Medical Association was held November 4 at the Mohican Hotel. William T. Foley, assistant professor of medicine at Cornell, spoke on anticoagulant therapy.

Charles Krinsky has been appointed to the Veterans Committee of the American Psychiatric Association. He recently returned from a meeting of that group in Washington.

Clemens E. Prokesch, M.D. announces the opening of his office for the practice of medicine at 58 Huntington Street, New London.

The October issue of *Cancer News* carried a photograph of the staff tumor conference at Lawrence and Memorial Hospitals, New London. The picture was included in the leading article entitled "Reward: 73,000 Saved in the doctor's office."

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## NEW BOOKS IN REVIEW

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*THE CONCEPT OF SCHIZOPHRENIA.* By W. F. McAuley. New York: Philosophical Library. 1954. pp. 143. \$3.75.

Reviewed by LUDWIG M. FRANK

In this well written little book, Dr. McAuley summarizes the present knowledge of schizophrenia, assesses its historical background and evolution, and points out the importance of heredity and environment in its development. The book is aimed at two groups of readers, medical students who contemplate specializing in psychiatry, and students who are preparing for examinations in psychological medicine.

An excellent historical review of the development of the concept of schizophrenia is provided. In this review the theories of Krapelin and his significant predecessors are exceptionally well summarized. The theories of Bleuler, Jung, Adler, Kretschmer, Meyer and others are presented in clear concise fashion. The role of heredity in schizophrenia is surveyed by consideration of the studies of Barret, Myerson, Rudin and principally of Kallman. The neurophysiological theories as well as the metabolic theories associated with schizophrenia are well surveyed and summarized and the need for further definitive research along these lines is indicated.



Dr. McAuley, who is both a practicing psychiatrist, as well as a teacher, leans rather heavily on a social-environmental explanation of the development of schizophrenia. In his chapter on this topic he expresses some of his personal beliefs and thus loses some of the objectivity provided by his otherwise well documented method of presentation. Such statements as "Man's chief difference from animals is that he has a highly developed nervous control which is used to develop an intricate social system which modifies, but principally masks, the influence of reproductive drives," seem to form the basis of the concepts he proposes. Although in this volume the dynamic faulty adaptation concept is espoused to be a cardinal point in schizophrenia, the theories of such significant figures as Sullivan, Brody, Rosen, and Fromm-Reichman who have recently done extensive research in the dynamics of schizophrenia are not mentioned. The theories of these researchers from the psychoanalytical school should appear in any modern compendium on schizophrenia.

The points to be considered in making the diagnosis of schizophrenia are clearly enumerated and discussed in a concise fashion. This discussion will be of particular value to the students towards whom this book is directed. Many psychiatrists would, however, question the recommended use of intravenous amytal or pentothal to demonstrate the presence of hallucinations or delusions as recommended in cases of doubtful diagnosis.

The discussion of treatment is limited to insulin coma therapy and leucotomy. Little or no mention is made of the use of electro-shock therapy, psychotherapy and rehabilitation procedures in the treatment of schizophrenia.

All in all, Dr. McAuley presents in this little book an excellent historical perspective, a well documented evaluation of the present status of neurophysiological and metabolic research, and a good chapter about making the diagnosis of schizophrenia. The more recent psychodynamic theories of schizophrenia have been omitted. Treatment methods are inadequately presented for the purposes of this book.

**PSYCHOANALYTIC PSYCHIATRY AND PSYCHOLOGY.** Clinical and Theoretical Papers, Austen Riggs Center. Volume 1. Edited by Robert P. Knight, M.D. New York: International Universities Press, Inc. 1954. 391 pp. \$6.

Reviewed by J. H. HOUCK

This book is a collection of twenty-three papers by staff members of the Austen Riggs Center at Stockbridge. Of these, Dr. Knight himself has written seven and Dr. David Rapaport, six. The other contributors are Aaron Beck, M.D., Margaret Brenman, Ph.D., Erik Erikson, Merton Gill, M.D., Roy Schafer, Ph.D., and Allen B. Whellis, M.D.

The volume covers a broad range of topics ranging from "A Critique of the Present Status of the Psychotherapies" to "Content Analysis in the Rorschach Test." The papers presented were chosen in the words of the editor "because we feel that they begin to shape up into an expression of a progressive point of view with respect to theoretical and clinical aspects of the closely related fields of psychoanalytic psychiatry and clinical psychology."

The book is divided—with some inevitable overlapping—into four sections. The first of these is a broad discussion

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by Dr. Knight on "The Present Status of Organized Psychoanalysis in the United States." The others are labelled Clinical, Clinical Psychological and Theoretical. It is indicative of the solid intellectual calibre of the Riggs staff that the last section is the longest.

Books of multiple authorship have an invariable unevenness of style, content and logical integrity, but in this one Dr. Knight himself sets a very high standard for his colleagues. His articles are distinguished by a straightforward simplicity and clarity of thought which is regrettably rare in psychiatric literature. The two papers on psychotherapy in particular could be read with profit by every psychiatric resident, analytic or otherwise. Even more useful from a clinical point of view are the two articles on the evaluation and management of the so-called "borderline states."

The section on Clinical Psychology is probably by design the smallest of the three major portions. In it Drs. Rapaport and Schafer discuss various aspects of psychological testing, mainly from a theoretical point of view. They have tried faithfully to adhere to the major theme of the book and relate their work to the larger topic of diagnostic and therapeutic psychiatry.

In the final portion of the book a good deal of effort is expended in the direction of psychoanalytic theory and metapsychology. Rapaport in particular has written at length although his articles, perhaps because of their content, are the most difficult to read. Though he makes no claims to have said the last word on these topics, his efforts

to base psychoanalysis firmly upon a solid academic foundation deserve attention.

Notable throughout all of this volume is the emphasis upon the various aspects of ego psychology. As the writers point out, this represents a fairly major change of focus in recent years, so that the comments upon ego strength, ego autonomy, etc., should be of interest to those who have been following this development of psychoanalytic theory.

This is a work of major proportions for a number of reasons. Not least of these is the implicit and explicit effort at integrating the various psychiatric disciplines in the interests of dynamic psychiatry as a whole. Dr. Knight is a psychoanalyst and proud of it, but he presents an unusually realistic approach to the virtues and limitations of the psychoanalytic technique and documents concisely the modern trend towards a broader integration of theoretical and clinical psychiatric concepts.

*USES OF WINE IN MEDICAL PRACTICE (A SUMMARY).* Wine Advisory Board: San Francisco, California. 1954. 42 pp.

This is an interesting and authoritative booklet covering chemical constituents of wines, wine and nutrition, wine in gastroenterology, cardiology, urology, neurology and psychiatry, in geriatrics and the treatment of the convalescent, in the treatment of diabetes, in the control of infections, and in pharmacy. It contains an extensive bibliography.





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